Delaware Medical Journal

ESTABLISHED 1776 — 1789 INCORPORATED

SEPTEMBER, 1961 . . .

STATE BOARD OF HEALTH ISSUE

ANNUAL MEETING PROGRAM

PAGE 249


THIS
CHESS
PLAYER
HAS
EPILEPSY...

With proper medical management and adequate control of seizures, epileptic persons may lead productive, functioning lives.[1,2] To implement this goal, many clinicians have come to rely on DILANTIN for outstanding control of grand mal and psychomotor attacks. For example, when DILANTIN was administered to 12 patients,[3] all but one remained seizure-free in the hospital after the diphenylhydantoin blood level had reached its maximum. This patient experienced a single convulsion but had "...no further seizures during the subsequent three and a half months of observation." DILANTIN SODIUM (diphenylhydantoin sodium, Parke-Davis) is available in several forms, including Kapseals, 0.03 Gm. and 0.1 Gm., bottles of 100 & 1,000.

DILANTIN®
SODIUM KAPSEALS®

HELPS KEEP HIS SEIZURES IN CHECK

other members of the PARKE-DAVIS FAMILY OF ANTICONVULSANTS for grand mal and psychomotor seizures: PHELANTIN® Kapseals (Dilantin 100 mg., phenobarbital 30 mg., desoxyephedrine hydrochloride 2.5 mg.), bottles of 100. for the petit mal triad: MILONTIN® Kapseals (phensuximide, Parke-Davis) 0.5 Gm., bottles of 100 and 1,000; Suspension, 250 mg. per 4 cc., 16-ounce bottles · CELONTIN® Kapseals (methsuximide, Parke-Davis) 0.3 Gm., bottles of 100. ZARONTIN® Capsules (ethosuximide, Parke-Davis) 0.25 Gm., bottles of 100. See medical brochure for details of administration, precautions, and dosage.

(1) Carter, S.: *M. Clin. North America* 37:315, 1953.
(2) Maltby, G. L.: *J. Maine M. A.* 48:257, 1957.
(3) Buchthal, F.; Svensmark, O., & Schiller, P. J.: *Arch. Neurol.* 2:624, 1960.

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PARKE-DAVIS
PARKE, DAVIS & COMPANY, Detroit 32, Michigan

FOUNDED 1776
MEDICAL SOCIETY OF DELAWARE
INCORPORATED 1789

Delaware Medical Journal

Official Publication of the Medical Society of Delaware

EDITORIAL AND BUSINESS OFFICES
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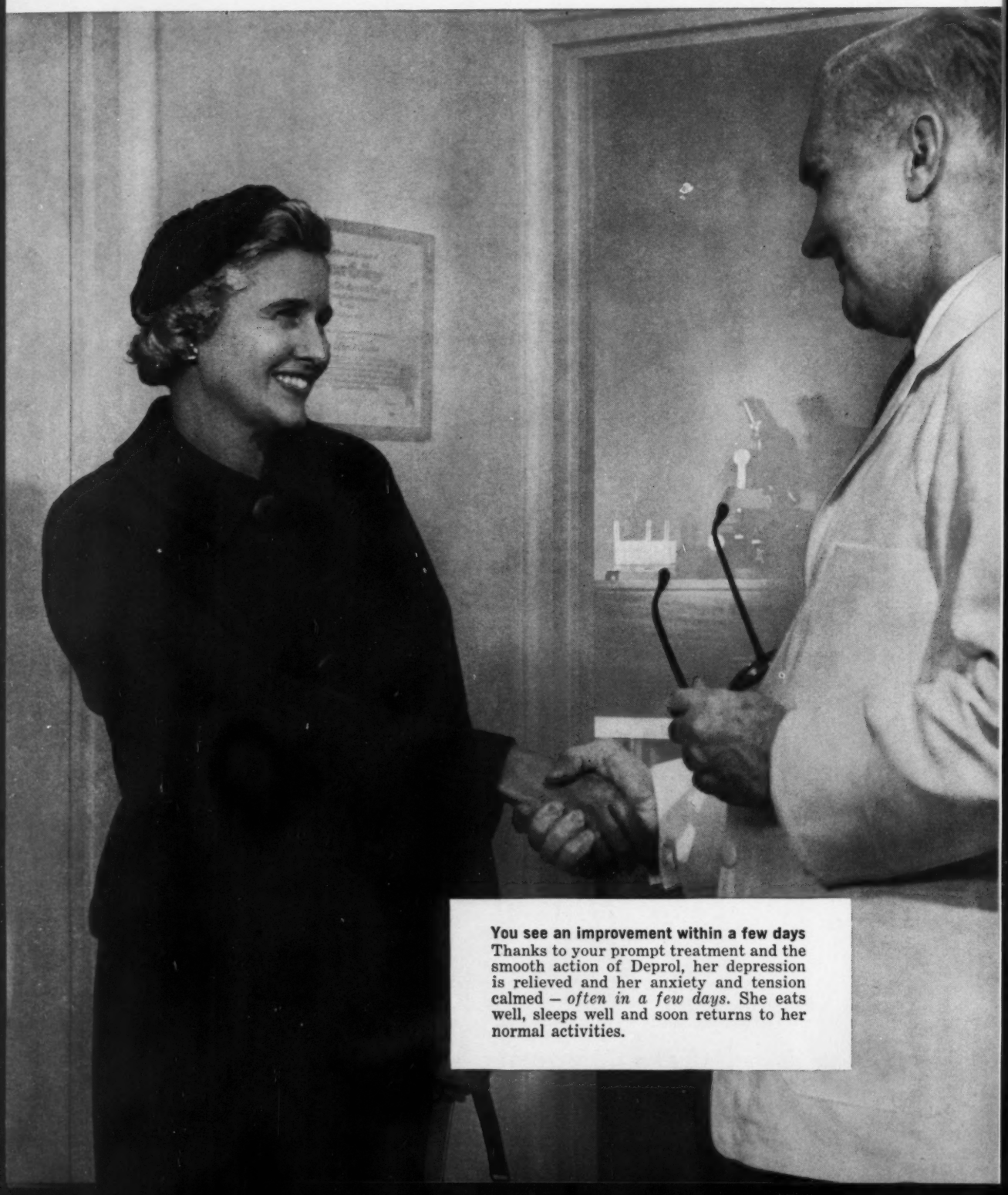
CONTENTS

Entered as second-class matter June 28, 1929, at the Post Office at Wilmington, Delaware, under the Act of March 3, 1879.
Issued monthly.

Lifts depression...



You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient *–they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation*–they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety–both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function–frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobamate and benactyzine hydrochloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gordon, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression – New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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CD-2848

Today's little "limey" needs a half barrel of orange juice

...or, to be exact, a total of 2,106 ounces in his first two years. And how much he'll need during his first twenty years would have to be measured by the truckload, because the need for the nutrients contained in Florida orange juice continues throughout life.

How our little "limey" or any of your other patients obtain the vitamins and nutrients found in citrus fruits is important to them and to you. There are so many wrong ways, so many substitutes and imitations for the real thing.

For a way that combines real nutrition with real pleasure, there's nothing better than the oranges and grapefruit ripened under Florida's own sunshine. Somehow, nothing can surpass the result of the combination of sun, air, temperature, and soil found in Florida.

It's good nutrition to encourage people to drink orange juice. It's even more judicious to encourage them to drink the juices and eat the fruits watched over by the Florida Citrus Commission. These men set the world's highest standards of quality in fresh, frozen, canned, or cartoned citrus fruits and juices.

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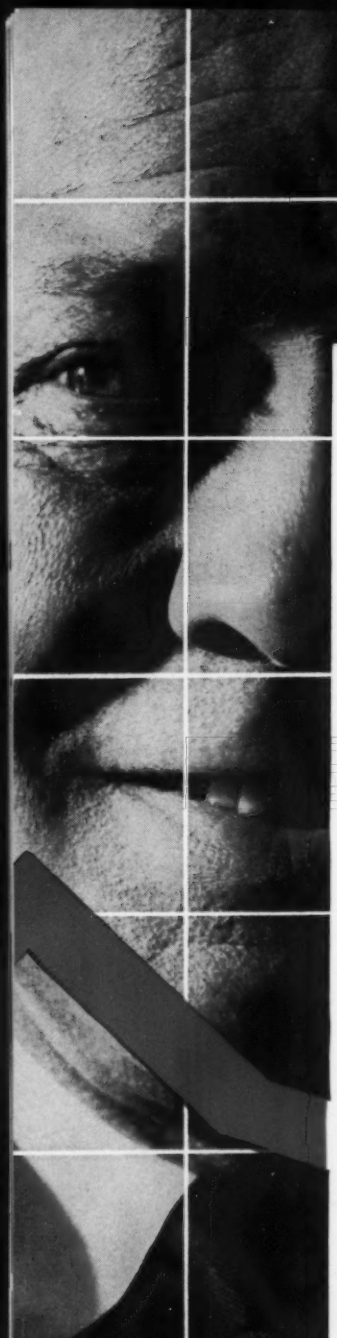

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Capla acts centrally at the brainstem vasomotor center

Capla reduces blood pressure by acting predominantly at the brainstem vasomotor center; is not a ganglionic blocker. It produces no depression, no postural hypotension, no nasal congestion, no gastric hyperacidity. Transient drowsiness sometimes occurs, usually at higher dosage.

New therapy

Alone, Capla is highly effective for mild to moderate hypertension. In more severe cases, it can be combined with diuretics or peripherally acting antihypertensives.

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Capla reduces both systolic and diastolic pressure usually in proportion to pre-therapy levels. Patients on Capla often report a mild calming effect. Capla has proved exceptionally well tolerated in clinical use and has no known contraindications.

RECOMMENDED DOSAGE: one tablet 3 or 4 times daily, before meals and at bedtime. Dosage should be adjusted to individual requirements.

COMPOSITION: each white, scored tablet, contains 300 mg. of Capla (mebutamate, Wallace).

SUPPLIED: bottles of 100 tablets.

Literature and samples to physicians on request.

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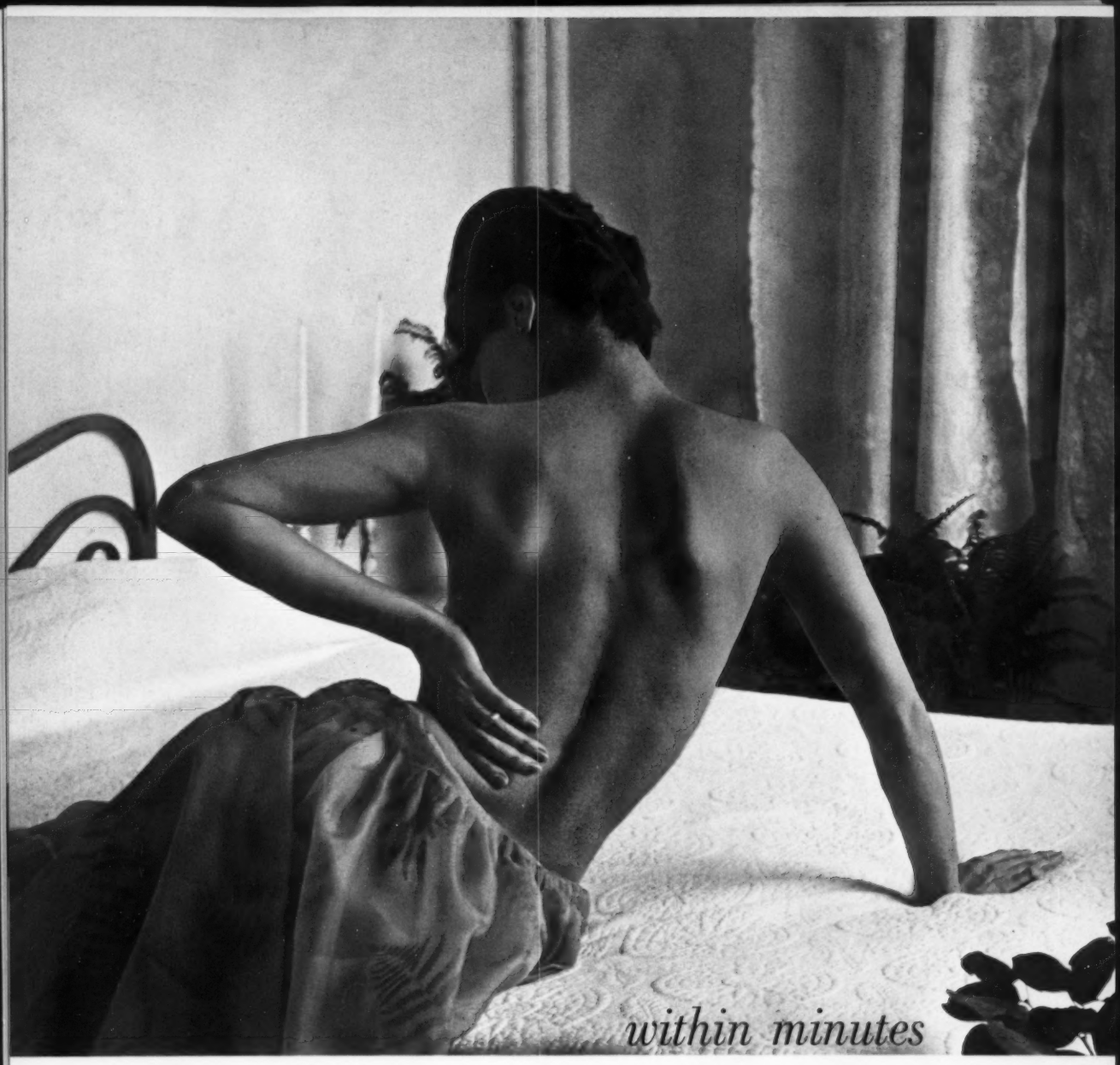
CLINICAL & PHARMACOLOGICAL REPORTS 1. Berger, F. M., and Margolin, S.: A Centrally Acting Blood Pressure Lowering Agent (W-583). Fed. Proc. *20*:113 (March) 1961. 2. Diamond, S., and Schwartz, M. Scientific Exhibit at Ill. State Med. Soc. Chicago, (May) 1961. 3. Douglas, J. F. Ludwig, B. J., Ginsberg, T. and Berger, F. M.: Studies on W-583 Metabolism. Fed. Proc. *20*:113 (March) 1961. 4. Duarte, C., Brest, A. N., Kodama, R., Naso, F., and Moyer, J. H.: Observations on the Antihypertensive Effectiveness of a New Propanediol Dicarbamate (W-583). Curr. Ther. Res., *2*:148-52 (May) 1960. 5. DuChez, J. W., Scientific Exhibit at Amer. Academy of Gen. Practice, Miami, (April) 1961. 6. Kletzkin, M., and Berger, F. M.: A Centrally Acting Antipressor Agent. Fed. Prod. *20*:113 (March) 1961. 7. Mulinos, M. G., Scientific Exhibit at Amer. Coll. Card. New York, (May) 1961. 8. Mulinos, M. G., Saltefors, S., Boyd, L. J. and Cronk, G. A.: Human Pharmacology Studies with W-583. Fed. Proc. *20*:113 (March) 1961. 9. Shubin, H., Scientific Exhibit, Amer. Coll. Card. New York, (May) 1961.



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WITHOUT DROWSINESS assure continued relaxation with

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Methocarbamol 'Robins'

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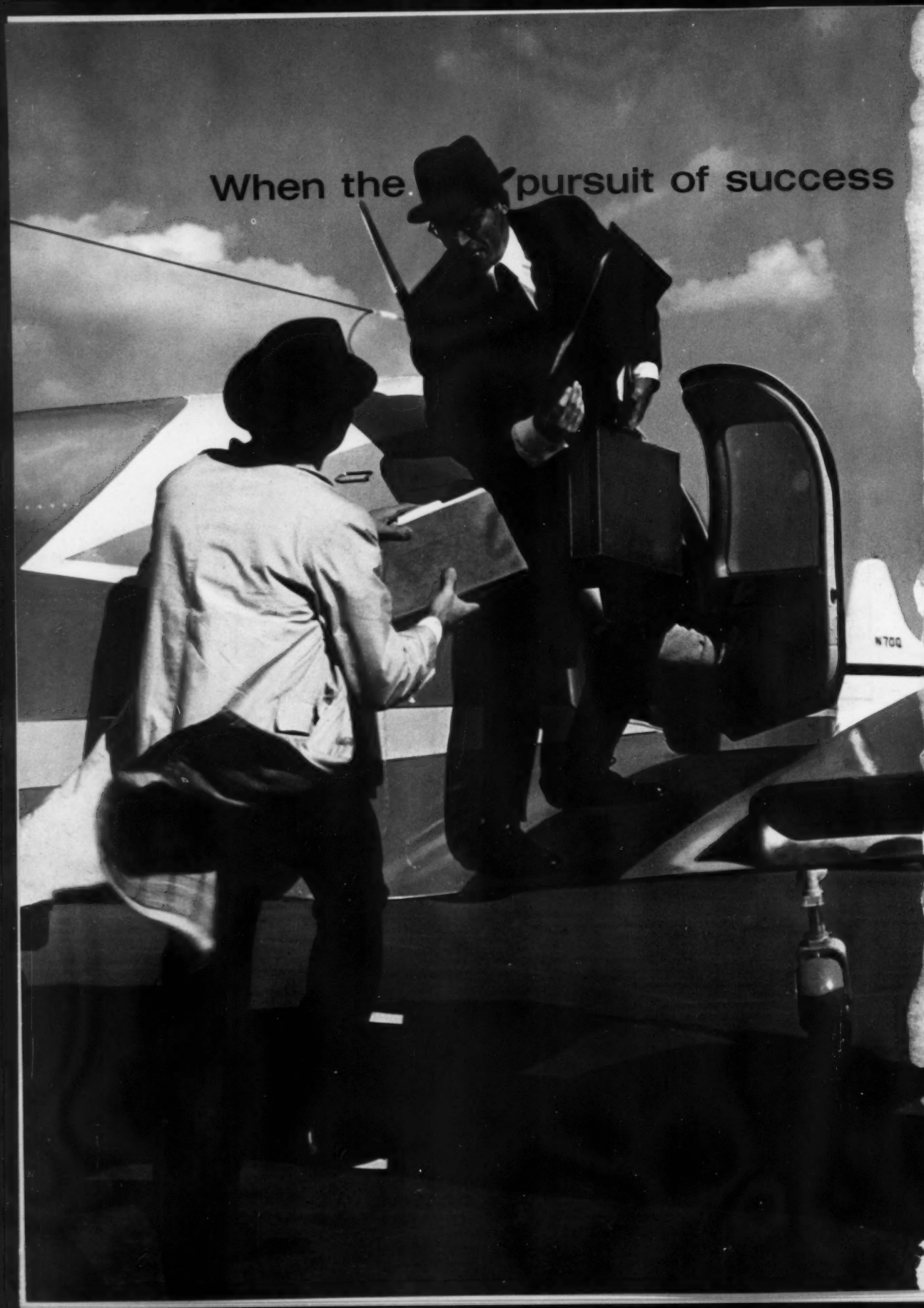
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Phenobarbital	(1/4 gr.) 16.2 mg.	(3/4 gr.) 48.6 mg.

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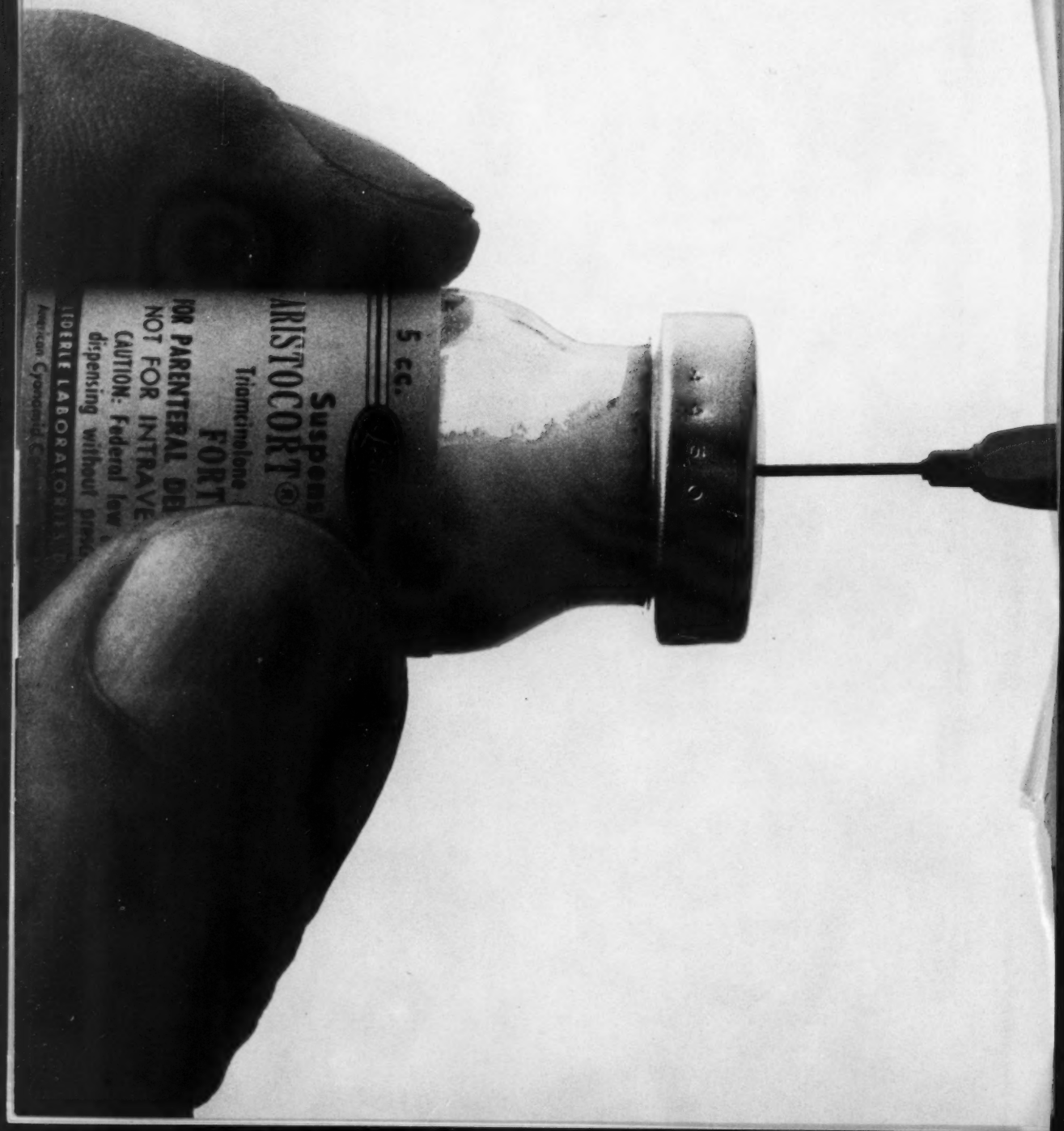

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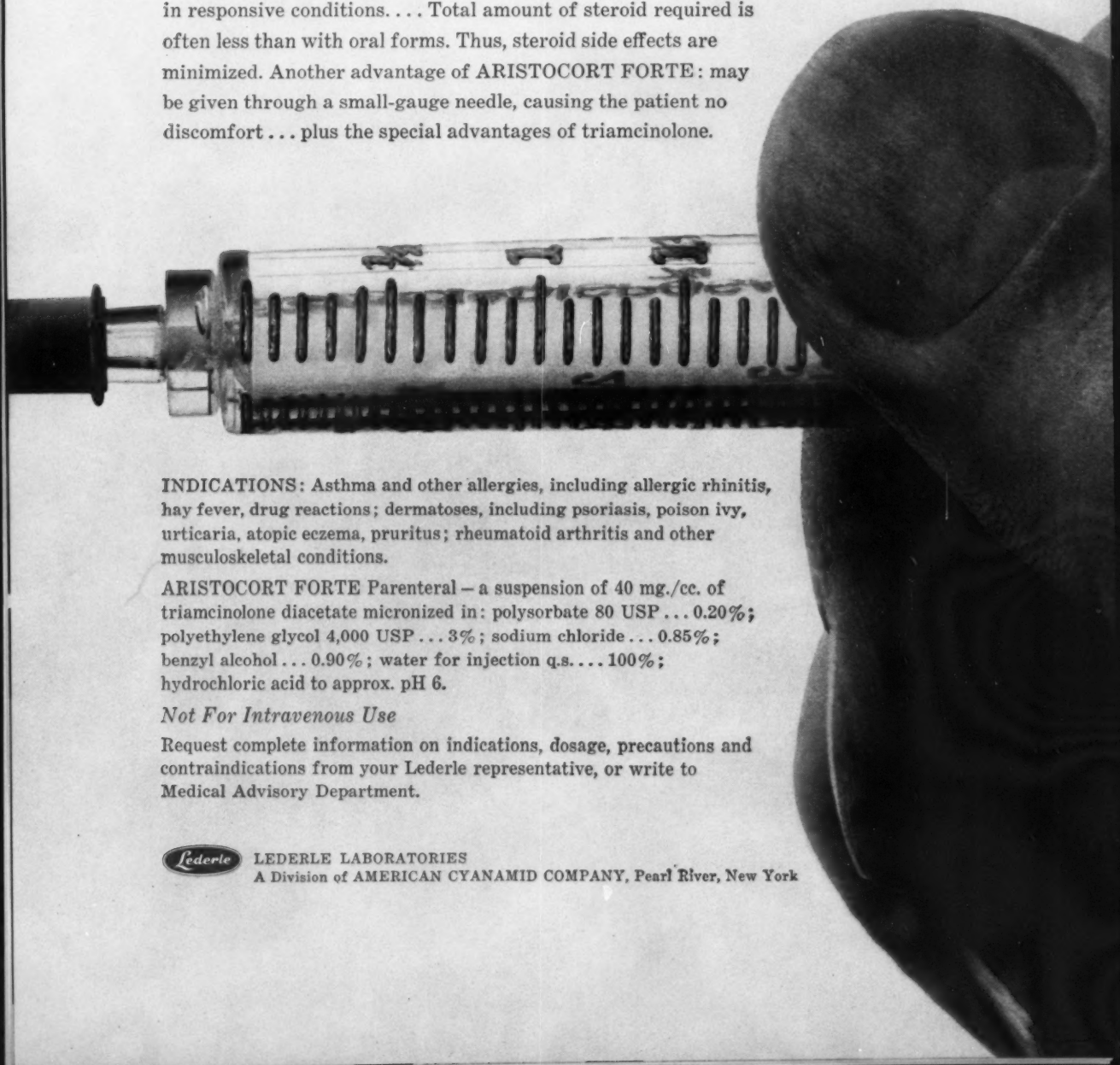
highly effective repository action with single, or infrequent, I.M. injections

Single I.M. doses of ARISTOCORT FORTE 4 to 7 times the usual daily oral dose can control symptoms 4 to 7 days, or even longer—sometimes up to 4 weeks in responsive conditions. . . . Total amount of steroid required is often less than with oral forms. Thus, steroid side effects are minimized. Another advantage of ARISTOCORT FORTE: may be given through a small-gauge needle, causing the patient no discomfort . . . plus the special advantages of triamcinolone.



INDICATIONS: Asthma and other allergies, including allergic rhinitis, hay fever, drug reactions; dermatoses, including psoriasis, poison ivy, urticaria, atopic eczema, pruritus; rheumatoid arthritis and other musculoskeletal conditions.

ARISTOCORT FORTE Parenteral—a suspension of 40 mg./cc. of triamcinolone diacetate micronized in: polysorbate 80 USP . . . 0.20%; polyethylene glycol 4,000 USP . . . 3%; sodium chloride . . . 0.85%; benzyl alcohol . . . 0.90%; water for injection q.s. . . . 100%; hydrochloric acid to approx. pH 6.

Not For Intravenous Use

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

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*New evidence** demonstrates the effectiveness of Terramycin in *otitis media* . . . another reason for the trend to Terramycin.

In a series of 41 cases of otitis media, Terramycin not only "was often successful where other antibiotics had failed," but also showed that "it is extremely well tolerated"; oral dosage for infants was 250 to 375 mg. daily, for children, 500 mg. to 1 Gm. In many instances, oral therapy was preceded by intramuscular injection of Terramycin.

The authors concluded that "there is good reason to consider it [Terramycin] one of the most effective agents for treatment of infection of the upper respiratory tract."

These findings confirm the continuing vitality and broad-spectrum dependability of Terramycin, as reported through more than a decade of extensive clinical use.

In brief

The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low order of toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions are rare. Aluminum hydroxide gel may decrease antibiotic absorption and is contraindicated.

More detailed professional information available on request.

another reason why the trend is to Terramycin—*versatility of dosage form:*

TERRAMYCIN Capsules—
250 mg. and 125 mg. per capsule—for convenient initial or maintenance therapy in adults and older children

TERRAMYCIN Intramuscular Solution—
50 mg./cc. in 10 cc. vials; 100 mg. and 250 mg. in 2 cc. ampules—preconstituted, ready to use where intramuscular therapy is indicated

Terramycin®

OXYTETRACYCLINE WITH GLUCOSAMINE

SYRUP PEDIATRIC DROPS

125 mg. per tsp. and 5 mg. per drop (100 mg./cc.), respectively

deliciously fruit-flavored aqueous dosage forms—conveniently preconstituted

Science for the world's well-being® Pfizer

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc.
New York 17, N. Y.

*Jacques, A. A., and Fuchs, V. H.: J. Louisiana M. Soc. 113:200, May, 1961.

Pfizer *Science for the world's well-being®*

Dear Doctor:

Reports from our representatives indicate that many physicians would appreciate simplification for prescription-writing purposes of the names of Terramycin products in both the "plain" and the "Cosa" dosage forms.

The "Cosa" forms originated, you may recall, on the basis of clinical evidence of enhanced antibiotic absorption when glucosamine is employed in oral administration. To permit each physician individually to study this evidence and choose which form he would prefer to prescribe, we offered Terramycin in both forms—that is, in the regular Terramycin forms without glucosamine, and in the "Cosa" forms with glucosamine.

This distinction appears to be no longer necessary since glucosamine, a highly acceptable excipient for oral antibiotics, now is being incorporated uniformly in all such forms, thereby simplifying nomenclature and your prescription writing.

Accordingly, and effective immediately, forms incorporating glucosamine will be offered simply as Terramycin without the "Cosa" prefix.

To make clear just which forms are affected, please refer to the brief tabulation (below) of Terramycin dosage forms both *before* and *after* this change. We are also requesting our representative to call on you at an early date to answer any questions that may arise.

We feel certain that this action, prompted by your comments and those of many other physicians, will simplify your writing of prescriptions for Terramycin products.

We welcome your comments on this action and on any other phase of our operations, since it is our objective to render every service as efficiently as possible to our friends in the medical profession.

Sincerely,
PFIZER LABORATORIES

The following table indicates the former name and the current name of Terramycin systemic preparations:

FORMERLY NAMED	NOW NAMED
Cosa-Terramycin® Capsules	**Terramycin**® Capsules*
Cosa-Terrabon® Oral Suspension	**Terramycin** Syrup
Cosa-Terrabon Pediatric Drops	**Terramycin** Pediatric Drops

and simpler names for these Terramycin-containing formulations:

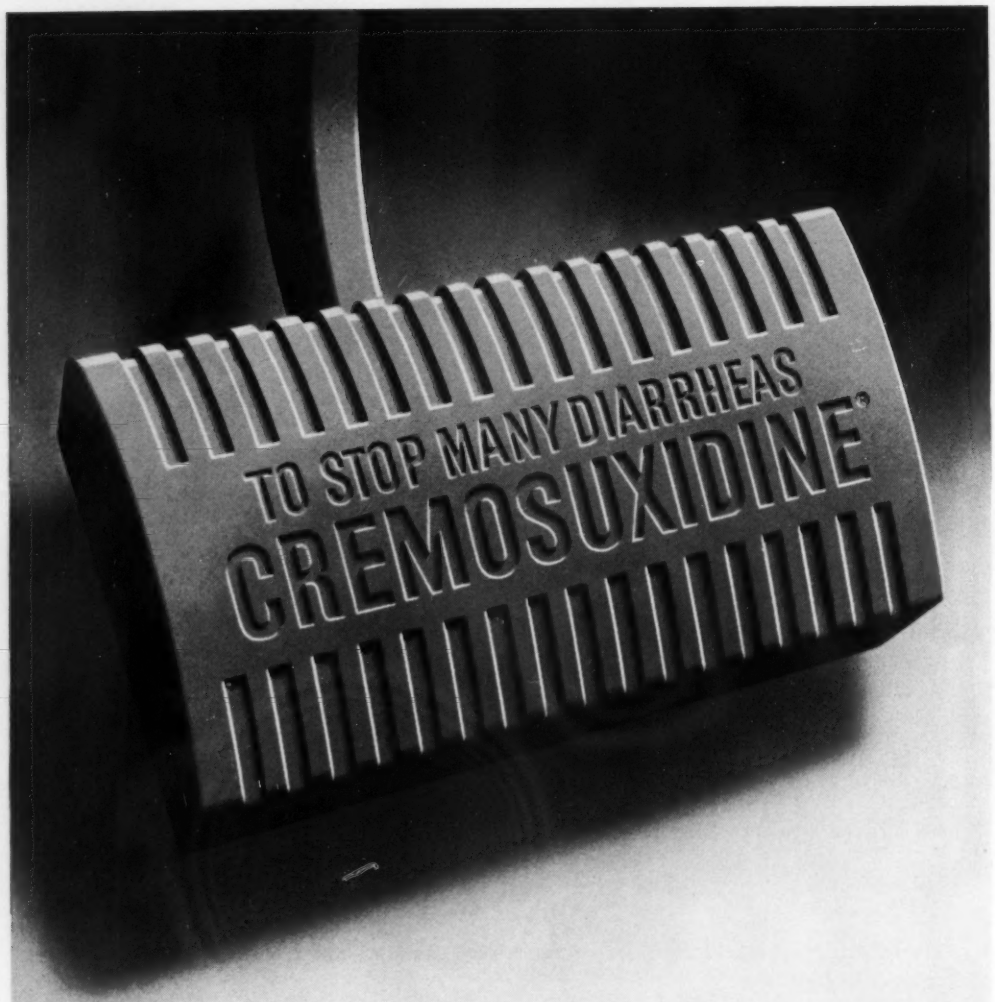
Cosa-Terrastatin® Capsules	**Terrastatin**® Capsules
Cosa-Terrastatin for Oral Suspension	**Terrastatin** for Oral Suspension
Cosa-Terracydin® Capsules	**Terracydin**® Capsules

. . . and these names remain unchanged:

Terramycin Intramuscular Solution
Terramycin Intravenous

**Terramycin Capsules* without glucosamine *are no longer available.*

The clinical versatility of Terramycin is enhanced by its specialized dosage forms adapted to individual needs—*another reason for the trend to Terramycin.*



effective, palatable, economical

CREMOSUXIDINE®[SULFASUXIDINE®SUCCINYLSULFATHIAZOLE SUSPENSION WITH KAOLIN AND PECTIN] reduces fluidity of stools, reduces enteric bacteria, adsorbs toxins, and soothes the irritated intestinal mucosa.

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If concern about effectiveness or high cost has kept you from prescribing any topical steroid... THESE FACTS MAY CHANGE YOUR MIND

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As to effectiveness, here is what a recent report* stated on the use of DILODERM in 53 cases of poison ivy dermatitis: "A satisfactory response...was seen in all cases. There were no cases of primary irritation or other side effects...."

As a matter of fact...you will find not only that DILODERM Cream is exceptionally beneficial in a wide variety of dermatoses responsive to topical steroids, but also that it costs *less* in most instances than generic hydrocortisone creams. In addition, DILODERM affords even greater savings over other topical steroids. Actually, the 15 Gm. tube of DILODERM Cream costs less than virtually all all other topical steroid preparations now prescribed.

As a matter of economy...the 15 Gm. tube of DILODERM is ideally suited for the treatment of large skin areas or extensive lesions. It *covers more* with *less waste;* it provides three times as much medication for only slightly more than double the cost of a small 5 Gm. tube of unbranded hydrocortisone.

We believe your patients with dermatoses will appreciate the significant savings DILODERM Cream affords, and that you, too, will agree... DILODERM in the 15 Gm. tube is *effective, economical in price,* and *even more economical in use.*

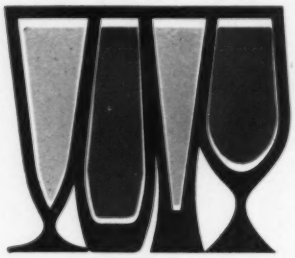
Also available: DILODERM Cream, 5 Gm. tube; NEO-DILODERM® Cream 0.25%, 5 and 15 Gm. tubes; DILODERM and NEO-DILODERM Foam, 10 Gm. dispensers; DILODERM and NEO-DILODERM Aerosols, 50 Gm. containers.

*Gant, J. Q., Jr.: *M. Ann. District of Columbia 30*:267, 1961.

For complete details, consult latest Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Bloomfield, New Jersey.

5-866

introducing...nutritional support in convenient, tasty, liquid form to supplement inadequate diets... to replace skipped meals



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nutritionally complete food

a nutritious meal, ready to drink

nutritional support is often needed for:

careless or irregular eaters—who skip breakfast or lunch or do not eat properly because of busy schedules or faulty eating habits.

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pregnant patients—who often require sound, easily tolerated, and convenient nutritional supplementation during pregnancy and lactation.[4]

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hospital patients—Nutrament liquid can serve as an excellent and convenient source of nourishment.

and in Oral, Dental or Surgical conditions—which interfere with or prevent consumption of solid food.

readily accepted by patients

Nutrament liquid requires no special preparation. Smooth texture and appealing taste of Nutrament make it readily acceptable. Equally delicious served hot or cold. Nutrament also has a high satiety value.

supplied

In 12½ fl. oz. cans, chocolate and vanilla flavors. Conveniently available at drug and food stores.

offers a scientifically balanced ratio of carbohydrate, protein, and fat. Each 12½ fl. oz. can of Nutrament liquid provides 400 calories. Caloric distribution: protein–20% (20 Gm.); carbohydrate–50% (50 Gm.); fat–30% (13.3 Gm.); plus the following vitamins and minerals:

		% MDR
Vitamin A (U.S.P. Units)	1250	30
Vitamin D (U.S.P. Units)	125	30
Vitamin C, mg.	50	166
Thiamine, mg.	0.5	50
Riboflavin, mg.	0.6	50
Niacinamide, mg.	5	50
Calcium, Gm.	0.5	67
Phosphorus, Gm.	0.4	53
Iron, mg.	4	40
Iodine, mcg.	60	60

Vitamin E (Int. Units)	2.5
Pyridoxine, mg.	0.4
Vitamin B_{12}, mcg.	0.5
Calcium pantothenate, mg.	2
Sodium, Gm.	0.2
Potassium, Gm.	0.9
Copper, mg.	0.5
Manganese, mg.	1
Fiber, Gm.	0.55

ingredients: Whole milk, skim milk, sugar, soy flour, Dextri-Maltose® (maltose and dextrins derived from enzymic action of choice barley malt on selected corn flour), starch, chondrus extract, sodium alginate, vitamin A palmitate, calciferol, sodium ascorbate, thiamine hydrochloride, niacinamide, ferrous sulfate, sodium iodide, *d*-alpha-tocopheryl acetate, pyridoxine hydrochloride, cyanocobalamin, calcium pantothenate, salt, cupric carbonate, manganese sulfate, cocoa and/or imitation vanilla flavor.

references: (1) Nelson, W. E.: Textbook of Pediatrics, ed. 7, Philadelphia, W. B. Saunders Company, pp. 231-233, 1959. (2) Parrott, R. H., and Nelson, W. E.: *ibid.*, p. 759. (3) Johnston, J. A.: Ann. New York Acad. Sc. *69*:881-901 (Jan. 10) 1958. (4) Burke, B. S., and Kirkwood, S. B., in Greenhill, J. P.: Obstetrics, ed. 12, Philadelphia, W. B. Saunders Company, 1960, pp. 126-131. (5) Skillman, T. G.; Hamwi, G. J., and May, C.: Geriatrics *15*:464-472 (June) 1960.

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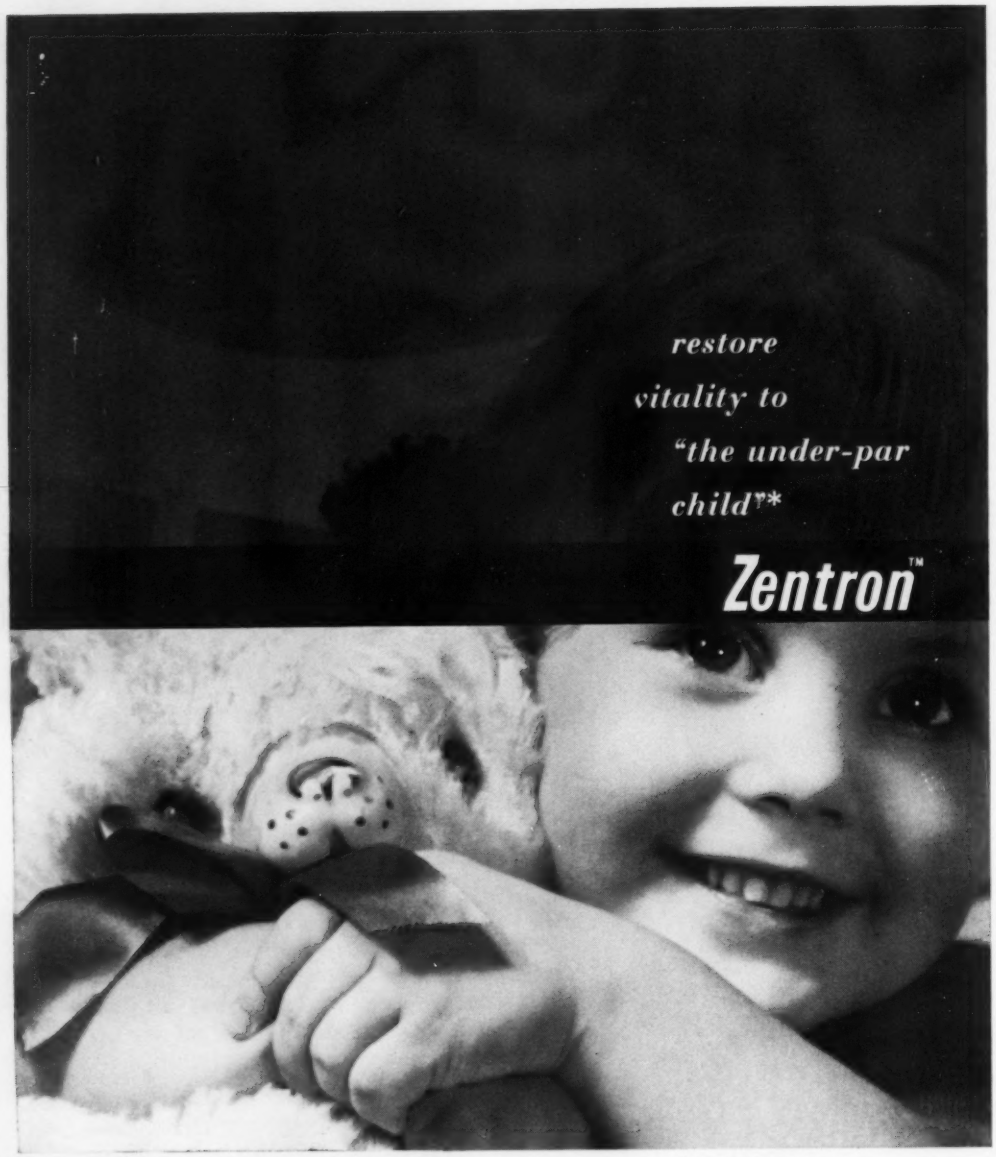
Quality products from nutritional research



Zentron • *comprehensive liquid hematinic*

corrects iron deficiency • restores healthy appetite • helps promote normal growth

**underweight, easily fatigued, anorexic—because of mild anemia*

Each 5-cc. teaspoonful provides:

Ferrous Sulfate (equivalent to 20 mg. of iron)	100	mg.
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Vitamin B_{12} Crystalline	5	mcg.
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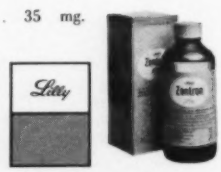
Alcohol, 2 percent.

Usual dosage: Infants and children—1/2 to 1 teaspoonful (preferably at mealtime) one to three times daily.

Adults—1 to 2 teaspoonfuls (preferably at mealtime) three times daily.

Zentron™ (iron, vitamin B complex, and vitamin C, Lilly) 119349



1776 -- MEDICAL SOCIETY OF DELAWARE -- 1961

INCORPORATED 1789

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Meets Third Tuesday

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Meets Quarterly, Sundays

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Alternates: E. H. Mercer (1961).

Councilors: H. G. Neese (1962); J. J. Lazzeri (1963).

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LEMUEL C. McGEE

President, Medical Society of Delaware, 1961

MEDICAL SOCIETY OF DELAWARE 1776-1789-1961

172nd ANNUAL MEETING

October 22 and 27, 1961 - Dover and Wilmington

PROGRAM

October 22

Treadway Inn, Dover, Delaware

2:00 P.M. House of Delegates

5:30 P.M. Buffet for Delegates

SCIENTIFIC SESSION (Morning)

October 27

Delaware Academy of Medicine, Lovering Ave., & Union St., Wilmington

9:00 - 9:30 Registration — Exhibits — Coffee

9:35 - 9:45 Welcoming Addresses — Andrew M. Gehret, M.D., President, New Castle Medical Society — and others

9:45 - 10:00 Report of the House of Delegates — Joseph W. Abbiss, M.D., Secretary

10:00 - 10:15 Presidential Address — Lemuel C. McGee, M.D., President

10:15 - 10:45 *Medical Problems In Manned Space Flight* — Willard R. Hawkins, Major, M.C., USAF

10:45 - 11:15 Recess — Exhibits

11:15 - 12:15 *Collagen Diseases* — Panel: Lawrence E. Shulman, M.D., Assistant Professor of Medicine and Director of the Connective Tissue Division of the Department of Medicine, Johns Hopkins University School of Medicine; Mary Betty Stevens, M.D., Instructor in Medicine, Johns Hopkins University School of Medicine; Robert M. Stroud, M.D., Fellow in Medicine, Johns Hopkins University School of Medicine

12:15 - 1:00 Election of President-Elect for 1961-62 — General Session — Exhibits

1:00 - 2:00 Luncheon, as guests of New Castle County Medical Society

2:00 - 2:30 *Medical Implications In Parapsychology* — C. B. Nash, Ph.D. Professor of Psychology, St. Joseph's College, Philadelphia

2:30 - 3:00 *Techniques of Cholesterol Reduction*, "A Multi-Faceted Approach To The Lowering of Blood Cholesterol," Edward S. McCabe, M.D., Editor, Lippincott Keystone Books in Medicine; Consultant in Medicine to the Surgeon General, U.S. Army

3:00 - 3:30 Recess — Exhibits

3:30 - 4:30 *What's New In Diagnostic Radiology?* Panel: Roy R. Greening, M.D., Professor of Radiology, Jefferson Medical College; Herbert M. Stauffer, M.D., Professor and Director of Radiology, Temple University School of Medicine; William J. Tuddenham, M.D., Professor of Radiology, University of Pennsylvania School of Medicine; James J. Boyle, Jr., M.D., Assistant Professor of Radiology, Hahnemann Medical College; Theodore A. Tristam, M.D., Assistant Professor of Radiology, University of Pennsylvania School of Medicine

4:30 - Adjournment

Note: The Delaware Diabetes Association will meet in the Academy of Medicine at 4:30 p.m.

Hercules Country Club, Wilmington, Delaware

6:30 - Reception and Cocktails

7:00 - Annual Banquet

PROGRAM OF THE THIRTY-SECOND ANNUAL MEETING

THE WOMAN'S AUXILIARY

TO THE MEDICAL SOCIETY OF DELAWARE

October 27, 1961 — Brandywine Country Club

Wilmington, Delaware

10:00 A.M. Registration and Coffee Hour

11:00 A.M. General Session
- Call to order—Mrs. J. Leland Fox
- Pledge of Loyalty
- Address of Welcome— Mrs. G. Barrett Heckler
- Response—Mrs. James F. Hays
- Introduction of Guests
- Roll Call of Delegates— Mrs. John B. Baker
- Minutes of the 31st Annual Meeting
- Treasurer's Report— Mrs. Emerson Y. Gledhill
- Reports of County Auxiliaries—
  - Kent—Mrs. James F. Hayes
  - New Castle— Mrs. Joseph J. Davolos
  - Sussex— Mrs. Aubrey C. Smoot, Jr.
- National Convention, 1961—
  - Delegate's Report— Mrs. H. Thomas McGuire
  - Report of the President— Mrs. J. Leland Fox
  - Report of the Nominating Committee — Mrs. Laurence L. Fitchett
- Election of Officers
- Installation of Officers— Mrs. Hewitt W. Smith
- Adjournment

1.00 P.M. Luncheon
- Invocation—Mrs. Charles E. Wagner
- Introduction of the Advisory Committee
- Greetings from the Medical Society of Delaware — Dr. Lemuel C. McGee
- Address — Mrs. Harlan English, National President, Woman's Auxiliary to the American Medical Association
- Presentation of Gavel and President's Pin
- Inaugural Address— Mrs. Joseph V. Casella
- Adjournment

EXHIBITORS

Booth No.

No. 1—Coca-Cola Company

Ice-cold Coca-Cola served through the courtesy and cooperation of the Delaware Coca-Cola Bottling Company, Wilmington, and The Coca-Cola Company.

No. 2—Willard L. Selby, Nicholas J. Reilly

Booksellers.

No. 3—Mead Johnson Laboratories

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

No. 4—International Business Machines

Exhibiting: The IBM Standard Electric Typewriter for all types of general correspondence, stencil writing, and carbon copy applications;
The IBM Executive Electric Typewriter with Proportional Spacing which sets and entirely new standard in the writing art. The distinctive appearance of letters done on this typewriter brings prestige to an office; and
The IBM Executary Dictating Machine which was designed for a better executive-secretary team. Some of its salient features are the use of a magnetic belt to record on; error-free dictation; unlimited review; and remote indexing.

No. 5—Schering Corporation

No. 6—Mutual Benefit Life Insurance

Representatives specially trained to understand the physician's financial problems will suggest solutions for them. Tax Calculator available at booth without obligation. Register for "Estate Planning for Physicians," other booklets, information and service on NSLI disability benefits.

No. 7—Tailby-Nason Company, Inc.

Professional representatives of the manufacturers of Betadine and Supertah, are taking this opportunity to introduce the latest addition to the Tailby-Nason family, Reactrol, an oral anti-allergenic, anti-pruritic tablet. Other products featured are Betadine Shampoo, Betadine Ointment, Betadine Antiseptic Solution, Supertah and Supertah Hydrocortisone. Your inquiries are cordially invited.

No. 8—Pfizer Laboratories

Booth No.

No. 9—Medco-Sonlators, Medcolators, Physical Therapy Equipment

Kol-Therm, used for hot or cold treatments, can be given either moist or dry and can be used in combination with electrical muscle stimulation, which gives gentle massage with either hot or cold. Fully automatic.
Medco-Sonlator provides complete facilities for combination of electrical muscle stimulation and ultra-sound. In many cases gives much relief in acute and chronic pain in a seven minute treatment.

No. 10—The Dietene Company

Meritene is the good-tasting protein-vitamin-mineral Food Supplement prescribed to provide concentrated nutrition for patients with poor appetite or tolerance for ordinary food. Visit our booth and let us serve you a cool, refreshing Meritene Nourishment. Review our Dietene Reducing Plan, designed to get better cooperation from over-weight patients. The Dietene Plan provides optimum nutrition and maximum satiety without the use of drugs.

No. 11—The National Drug Company

Tepanil, Tepanil Ten-Tab and Orenzyme are being featured at our exhibit. Tepanil is a completely new compound that curbs the appetite with little or no CNS stimulation.
Orenzyme is the first oral anti-inflammatory enzyme tablet on the market. Orenzyme is indicated for the treatment of any acute inflammatory process when swelling slows recovery.

No. 12—Delaware State Board of Health

The exhibit will show the various services available to physicians for their handicapped child patients. These services include orthopedic, neurological, orthodontic, cleft palate, hearing and speech abnormalities.

No. 14—Thermo-Fax Sales, Division of Minnesota Mining & Manufacturing Co.

Demonstration of the latest business system used for statement preparation. Statements can be prepared for as little as 1c each, in four seconds time. Days of work are condensed into hours. In addition, see the latest in visual aides for training purposes.

No. 17, 18—John G. Merkel & Sons, Inc.

No. 20—Baker Laboratories, Inc.

You are invited to visit our booth where Baker's Modified Milk and Varamel, two successful products for infant feeding are on display.
Baker representatives will be glad to

EXHIBITORS

Booth No.

discuss the benefits of Baker Milk products which provide all the normal dietary requirements plus a reserve for stress situations.

No. 21—Roche Laboratories

Exhibiting: Librium — A therapeutic agent for superior, safer, faster control of nervousness, anxiety, tension and other common emotional disturbances without the dulling effect or depressant action of the tranquilizers; Madribon — A completely different, low-dosage, sulfonamide of particular value in the treatment of bacterial infections, especially respiratory infections; and
Tigan — A specific antiemetic agent effective both prophylactically and therapeutically against most clinically significant types of nausea and vomiting.

No. 22—Robert Ramsdell, Simplified Tax Records of Delaware

No. 24—Warner Lambert

No. 25—Bertholon-Rowland, Inc.

No. 30—Delaware League For Planned Parenthood, Inc.

Literature of particular interest to the medical profession, will be available. The Delaware League for Planned Parenthood, a state-wide agency, maintains a four point program: birth control clinics; infertility clinics; education for marriage and parenthood and support of research.

Booth No.

No. 32—A. H. Robins

For relieving many symptoms of the season's common colds, prescribe Dimetapp Extentabs and Dimetane Expectorant. Dimetapp Extentabs provide the unexcelled antihistaminic properties of Dimetane plus the decongestant actions of phenylephrine and phenylpropanolamine. With glyceryl guaiacolate these same compounds form Dimetane Expectorant.
For superior expectorant action alone, prescribe Robitussian. And for a therapeutic multivitamin, Adabee.

No. 34—Doho Chemical Corporation

Auralgan — for relief of pain in Otitis Media and removal of Cerumen; Rhinalgan — nasal decongestant; Otosmosan — for suppurative and aural dermatomycotic ears; Larylgan — for infectious and non-infectious sore throat involvements; Biotosmosan HC — antimicrobial, anti-inflammatory, deinflammatory, anti-allergic, antipruritic, (contains Hydrocortisone). Dermoplast — bactericidal and fungicidal aerosol spray especially useful in Obs-Gyn.; Rectalgan — liquid topical relief of pain and itching in hemorrhoids, pruritus, etc.; Rectalyt HC — water-miscible polymer vehicle containing Hydrocortisone.

No. 36—Eli Lilly and Company

You are cordially invited to visit the Lilly exhibit located in space No. 36. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

CURRICULUM

FOR DELAWARE TWO-WAY RADIO MEDICAL CONFERENCES

OCTOBER, 1961 SCHEDULE

TOPIC AND FACULTY

October 3	"Juvenile Delinquency." Philip Q. Roche, M.D., Asst. Prof. Graduate School of Medicine, University of Pennsylvania
October 10	"Modern Indications for Cesarian Section." Edward H. Bishop, M.D., Asst. Prof. OB-Gyn., University of Pennsylvania School of Medicine
October 17	"Dysfunctional Uterine Bleeding." James D. Garnet, M.D., Asst. Prof. Clinical Ob-Gyn., Graduate School of Medicine University of Pennsylvania
October 24	"Headache." Joseph B. Green, M.D., Asst. Neurologist to Pennsylvania Hospital
October 31	"Food Allergies, First Year of Life." George Blumstein, M.D., Assoc. Prof. of Medicine, Temple University School of Medicine

Delaware Medical Journal

SEPTEMBER, 1961
VOLUME 33
NUMBER 9

IMPROVING DELAWARE'S NURSING HOMES

• Care of chronic disease and diseases of the aged is assuming much importance. This article explains how nursing homes may fit into the total picture.

FLOYD I. HUDSON, M.D.

Nursing homes are considered an important link in the medical care of persons convalescing from acute diseases or suffering from chronic disease of long standing. At the National and State levels much thought has been given to the question of how a nursing home may best serve persons for whom care is provided. The State Board of Health has been interested in this subject along with the Medical and Dental Societies, the Hospital Association and the Association of Nursing Homes for the past decade. Regulations adopted by the Board have been in effect since 1946. A more extensive amendment to these regulations was added five (5) years ago.

All homes in Delaware offer most of their services to debilitated persons who are sixty-five (65) years of age or older. The State also provides a nursing home type of care in the Welfare Home and Hospital for Chronic Illnesses at Smyrna. It is understood that most of the State services are utilized by persons who may be classified in the senior citizen group. The general hospitals of Delaware also provide care to a substantial number of older persons. A study of the use of general hospital beds by persons over age sixty-five (65) in 1959 showed that sixteen (16) percent of these senior citizens were unable to pay for their entire hospitaliziation.

Within the last year several organized groups have expressed interest in the programs offered in the nursing homes of the State. The Council for improving care of the aged became active with representation from the State Medical Society, the State Dental Society, the Association of Delaware Hospitals, the Delaware Association of Nursing Homes and the Hospital Administrators Association. In the considerations of this group there was stressed the need for improving generally the conditions in some of the nursing homes. This resulted in the formation of a new corporation which aims at the voluntary self-improvement of our nursing home facilities. The organization is called the Delaware Council for the Accreditation of Nursing Homes. This is indeed a creditable effort

Dr. Hudson, M.P.H., Johns Hopkins, '47, has been Executive Secretary of the Delaware State Board of Health since 1949.

and assures better care for patients in these institutions in future years.

The State Board of Health early in 1960 discussed at great length the desirability of developing a statewide program to increase and improve the nursing and other services now provided in existing nursing home situations. Funds were a limiting factor. Federal Public Health Service funds were made available and a qualified nurse was then sought to carry further teaching, consultation and inspection into the nursing home picture. It was agreed by the Board that the evaluation of existing nursing home situations should be made by qualified registered nurses, sanitarians, local health officers, the Fire Marshall and others. The Deputy State Health Officers in each county were directed by the Board to work with a newly selected staff nurse to offer services at each nursing home.

Essential Items

In evaluating the total program, a survey of the needs in each community were elicited. Special attention within each home itself was placed on the following list of items which were essential in the operation of any nursing home:

1. Building and design.
2. Equipment.
3. Environmental health and plant maintenance.
4. Accident prevention.
5. Fire Safety.
6. Physician services.
7. Dental services.
8. Nursing services.
9. Physical therapy.
10. Occupational therapy.
11. Food services.
12. Social services.
13. Recreational services.
14. X-ray and laboratory services.
15. Pharmaceutical services.
16. Patient and family education.
17. Central referral and placement.
18. Mental health and mental illnesses.
19. Relation to hospitals (and other medical facilities).
20. Overall operating policies.
21. Personnel management and policies.
22. Medical records.
23. Recruitment and training (agency and home).

All licensed nursing homes were visited, inspected, and personnel was interviewed. Nearly all appeared to be clean and devoid of odors. Sanitary equipment was generally adequate and in most cases better than that outlined in our regulations. From a cleanliness point of view, the chief fault was what we choose to call "clutter." There were numerous instances of much more furniture than necessary and certainly more than could be readily utilized. Bedside tables most frequently were crammed with bottles, pill boxes, sanitary tissues, basins, urinals, old letters, cards, books, magazines and occasionally a plant. This clutter appeared to prevent an efficient functioning of nursing home personnel. Although the layout of many of these homes is not the best, we emphasized the advantages of orderliness. A place for the most usual items resulted in smoother and more unhampered operation.

The chief nurse along with the sanitarians, stressed demonstrated need for training and education among operators and personnel. For example, there seemed to be general misunderstanding about the psychology of the aging process. Most persons would not know where to draw the line between normal old age behavior, with some childish habit patterns, and senile dementia.

Diet and nutrition training are essential. Assistance is particularly needed in special diets such as low sodium, low fat, or diabetic diets. One operator refused to provide an apple to an elderly male diabetic. We felt that such situations are probably repeated many times.

Physical activities for the aged cannot be replaced. A bed-fast patient is usually a lost one. It is necessary to get elderly people out of bed regardless of condition. Nursing home personnel do not understand generally simple body mechanics. Patients

who are heavy or paralytic are remaining bed-fast because of this lack of knowledge. Nurses and attendants are needed to demonstrate how easy it really is to employ simple body mechanics to get a patient out of bed. Physical and occupational therapies are almost entirely lacking. It was suggested to operators that wide use be made of the booklet "Strike Back At Stroke." There were practically no activities in the hobby and recreational fields.

Communications and records are poor in most instances. Referrals are frequently made verbally by physicians, hospitals, and nursing home operators. Record keeping is inadequate and may be anything from memory to a composition book—occasionally there will be loose leaf records. The entire staff who worked on this project recommended that standard forms be provided for all nursing homes and that they be taught to use them.

In evaluating the results for this year's project to improve nursing home care, it is clear that many improvements need to be made. A few of these delinquencies have been outlined in the above paragraphs. The State Board of Health plans to extend its work for the next year in improving the nursing care, rehabilitation and some of the other things mentioned above. An Institute was held at Emily P. Bissell Hospital on June 8, 1961, where some of these matters were discussed. Further training in good nursing home care will be a part of our expanded program for at least the next year. We know that the physicians of the State of Delaware will be interested in the benefits which will come to their patients from this course of action.

DELAWARE PHYSICIANS INVITED

The 13th Annual Scientific Assembly of the Maryland Academy of General Practice will be held at the Tidewater Inn, Easton, Md., on Saturday and Sunday, October 7 and 8, 1961. The program for the two day session is as follows:

Saturday, October 7, 1961

9:30 A.M. Registration

10:00 A.M. Milton S. Sacks, M.D., Baltimore, *Drug Induced Blood Dyscrasias*

10:40 A.M. J. Robert Willson, M.D., Philadelphia, *Obstetric Difficulties*

11:20 A.M. Edmund J. McDonnell, M.D., Baltimore, *Office Pediatric Orthopedics*

Noon Round Table Luncheon

1:30 P.M. Panel Discussion on Morals in Medicine, Andrew C. Mitchell, M.D., Salisbury, Moderator. A representative of each of the three faiths, Protestant, Catholic, and Jewish will be participants.

3.30 P.M. Annual Business Meeting

6:30 P.M. Reception and Cocktail Hour

7:30 P.M. Annual Banquet

Sunday, October 8, 1961

9:30 A.M. Registration

10:00 A.M. Patrick C. Phelan, Jr., M.D., Baltimore, *New Treatment of Burns*

10:30 A.M. C. Parke Scarborough, M.D., Baltimore, *The Role of Plastic Surgery in the Practice of Medicine*

11:00 A.M. F. Ford Loker, M.D., Baltimore, *Minor Surgical Office Procedures*

Noon Round Table Luncheon

1:30 P.M. Panel Discussion on Cardiac Disturbances, Nathan E. Needle, M.D., Baltimore, Moderator

Participants:

Henry J. L. Marriott, M.D., Baltimore, *Clinical vs. Electrocardiographic Diagnosis of Heart Disease*

R. Adams Cowley, M.D., Baltimore, *Use of Surgery in the Correction of Heart Defects*

Jonas R. Rappeport, M.D., Baltimore, *The Psychiatric Factor in Treatment of Heart Disease*

3:30 P.M. Adjournment

Note: *Each lecture will be followed by a 10 minute question and answer period.*

WILL YOU BE THERE?

• Because the growing importance of shelters to protect against radioactive fallout is being stressed, the construction of such a shelter is presented and described in the following article.

GEORGE F. CAMPANA, M.D.
O. EUGENE TRIVITS, B.S.

Will you be among those "present and accounted for" when the survivors are tabulated after an aggressor has unleashed a thermo-nuclear attack on "That Day"? To be sure, we don't know if there will ever be a "That Day"—we can only hope not. However, the threat of thermo-nuclear conflict remains ever present, perhaps today more than ever. It has become a well known fact that atomic strikes on this country will result in destruction of devastating proportions and in deaths numbering in the millions. However, contrary to the fictitious theory of Nevil Shute's best selling novel and movie On the Beach", this will not signal the start of world wide contamination and the complete destruction of mankind. There is no doubt that the large mass of survivors will greatly outnumber the fatalities after the initial attacks, and all of us would like to be among the living. Yet Americans must face and accept the fact that no one can predict where the actual detonations will occur and who and how many will succumb to their blast and heat effects.

But the danger does not stop with the explosion; it begins anew. The added phenomenon is the much talked about, but little understood, FALLOUT. This potential killer is perhaps far more insidious than the normal explosive effects of blast and heat, since it can well stalk its victim unobserved. Fallout cannot be detected by the usual senses of sight, touch or smell. It very definitely can be a lethal threat to many more citizens in addition to those already victimized. Without an understanding of radioactive fallout and a provision for protection from it, millions would die who otherwise could survive. Put more positively, millions of Americans could save their lives by learning what to do—and doing it.

Aside from the personal viewpoint, members of the medical profession have reason over and beyond that of the ordinary layman for being included as one of those "present and accounted for." The disparity between the demand for medical aid and that available would be wide enough if no losses were to occur within the ranks of medically trained persons. The numbers of casualties among survivors will be staggering, and without medical help, many will have no hope. Therefore, each of you who survives the blast and then allows himself to become a victim of fallout, will in effect be writing off hundreds who might otherwise be saved. Yet simple logic makes one realize that many of these desperately needed skillful workers will not survive. Thus, it seems not only desirous but man-

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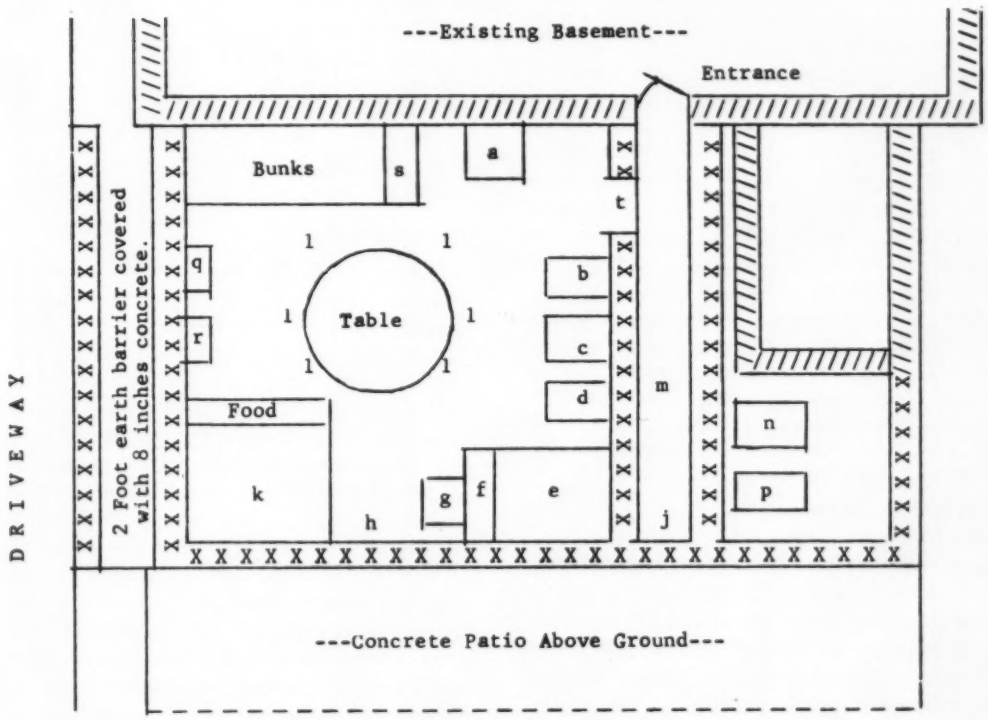
Mr. Trivits, B.S., U.S.P.H.S., is Program Representative for the Division of Health Mobilization, U. S. Public Health Service, assigned to the State of Delaware.

datory that physicians, nurses, dentists, veterinarians, and all other members of the medical and allied medical fields do all in their power to help insure that they will be a survivor of *all* the effects of nuclear warfare, and ready to put their knowledge and skills to work in the recovery period.

The question is then, "How can I do all that is necessary to maximize my chances for survival?" The answer—Investigate the entire situation as it relates to you, and then take immediate measures to meet the threat. First then, a review of the problem.

BASEMENT FALLOUT SHELTER (Figure 1)



LEGEND.

/ / / / Existing Foundation Walls
X X X X Installed Concrete Block Walls

a. Hand-wind record player
b. File Cabinet
c. Medical Supplies
d. Charcoal Stove
e. Toilet Facility
f. Medicine Cabinet
g. Wash Basin
h. Emergency Exit No. 1
j. Emergency Exit No. 2
k. Storage for tools, charcoal, strong box
l. Folding chairs
m. Drain for shower
n. 55 gal shower water
p. 55 gal. drinking water
q. Battery radio
r. Radiological instruments
s. Books and games
t. Entrance (3 steps down)

TABLE I

Gamma Ray Radiation Effects On Humans

Dose	*Effect*
100 roentgens	No obvious effects
100-200 roentgens	Minor incapacitation and inability to carry on normal activities
200-600 roentgens	Major to total incapacitation and acute sicknes. Some deaths will occur.
600 or more roentgens	Total incapacitation. Many deaths; very few survivors.

Radioactive Fallout . . . What Is It?

When a nuclear explosion occurs on or near the earth's surface, the intense heat and force of the explosion vaporizes large quantities of earth, and other materials. This material is borne aloft by the violent updrafts caused by the explosion. Here it becomes mixed with the intensely radioactive fission products of the bomb. It cools and then falls to earth over a wide area. This, then, is the material known as radioactive fallout.

Distribution Of Fallout

The characteristic mushroom shaped cloud, which carries the radioactive material, may rise to heights of 15 to 20 miles before it begins to disperse as a result of the wind currents. No one can predict for sure where the fallout will be deposited. The type and size of the bomb, weather conditions, and the number of bombs exploded all will determine the extent of fallout. It usually will take at least an hour for dangerous amounts of fallout to arrive on the ground, outside the immediate blast area. This is a very important point, because it accentuates the falsity of the fatalistic thinking of those who say "Why even try to prepare. If the blast doesn't get me, the radioactive fallout will anyway." But one can readily see that with the hour between blast and fallout's arrival (and this time interval can be six hours or more), one has time to go considerable distances and do many things to protect himself. Nearly all fallout will reach the ground within two days after the explosion, but even so, such fallout can cover thousands of square miles.

Effects Of Fallout

Fallout might be compared to a nearly invisible snowstorm—it covers all exposed objects, buildings and persons. The chief danger to humans from fallout is the Gamma rays, which are emitted from the radioactive fallout particles. These particles, like X-rays, are very penetrating and can cause fatal damage to living tissue. Dosage of radioactivity is expressed in units of measure called roentgens. Table 1 shows the probable effects on humans as a result of receiving various dosages of Gamma radiation within a short time period (one day to one week). As indicated, a dose of over 600 roentgens is nearly always fatal. The need for protection from these rays is obvious.

The Protection Factor

If you have protection from fallout, time is on your side. From the time of its formation when the explosion occurs, radioactivity decreases. The rate of decay shortly after the explosion is extremely rapid. The time of greatest danger is in the first few days following the attack. To illustrate an initial radiation reading of 3000 roentgens per hour immediately after the blast, will probably be reduced to a reading of 300 roentgens per hour just seven hours after.

Forty-eight hours later, this reading will be only 30 roentgens per hour and 2 weeks after the initial reading the radiation level will be a mere 3 roentgens per hour. Thus time becomes one of the most important factors of protection.

The theory of time as an ally in combating the effects of radioactive fallout is only valid if one has provided a method of shielding oneself from the fallout and thus prevents exposure to the outside radiation level until sufficient time has elapsed to allow decay to a safe degree. Shielding may be obtained by interposing material barriers between the person and the radioactive sources. The relative shielding value of some common barrier materials is illustrated in Table 2. Various combinations and thicknesses of these materials will offer you protection by reducing to a safe level the penetration of Gamma Rays.

TABLE II

Relative Shielding Value of Materials

Material	*Outside Radiation Admitted*
Glass	90 percent
Wood Sheathing	70 percent
Brick Veneer Wall	30 percent
8" Solid Concrete Block	12 percent
12" of Earth	12 percent

While there are innumerable plans and articles available on the design and value of various fallout shelters, it is perhaps more interesting to review and evaluate a case at hand. Dr. George F. Campana, co-author of this article, surveyed his personal requirements for shelter protection several months ago. Proposed alteration and addition to his existing home offered an excellent opportunity to install a fallout shelter. Dr. Campana designed the shelter that now is a part of his home at 424 N. Bradford Street, Dover. (see Figure 1.). Careful consideration was given to the utilization of existing barrier protection factors as well as to the selection of materials used in the new shelter walls. While a portion of the work was done by an outside contractor, much was done by Dr. Campana himself. This brings up the factor of cost. Basic fallout shelters can be constructed on a do-it-yourself basis for as little as $100 for materials. However, providing a more improved and habitable shelter living area requires larger investment. Certainly, the amount of funds available restricts the type and extent of the project. Dr. Campana has estimated that the erection and stocking of his shelter will represent expenditures of approximately $2000. He points out, however, that he considers this very low cost insurance against the threats of nuclear fallout *and* possible damage and injury likely to result from natural disasters, such as hurricane or tornado. In addition, he feels that this is a one time expense, which, when considered over a period of years, is truly inexpensive. By combining the building of the shelter with other construction, additional savings were realized. Finally, utilization of the shelter for storage and recreation makes it even more desirable, and also reduces its effective costs.

The top of the shelter is situated 20 inches below ground level. As can be seen in Figure 1, there is more than ample earth and/or concrete barrier on 3 sides, and the existing basement walls offer adequate protection on the fourth. The ceiling is supported by a steel beam and heavy hard wood rafters. This is covered by a 6 inch layer of dense composite roofing material plus several thicknesses of roofing paper. All of this is topped by 2 sheets of sheet steel roofing 3/16 thick. Additional barrier mass for the ceiling is obtained in the materials of the pantry and den above with its additional roofing material.

In addition to the shelter construction itself, many other factors have been considered. Life underground for periods of possible two weeks or longer presents many unique problems. To start with, it was recognized that Dr. Campana may well not be at home at the time of attack. Therefore, he provided a 55 gallon supply of water in a separate compartment outside

of the cellar and shelter itself so that he can take a decontamination shower upon arrival (see m & n, Figure 1). In addition to the shower water, 55 gallons of drinking water is also treated in this area (p, Figure 1). Once inside the shelter, provisions for living for extended periods have been provided. Many of these are readily apparent after studying Figure 1, but some detail is not shown or bears special mention. A supply of bedding and extra clothing is stored for long term storage in plastic coverings that also help prevent any formation of mildew. Flashlights (with spare batteries and bulbs), candles, and kerosene lamps are available for illumination. A second hand stove that burns charcoal is provided for heat and cooking. The round table takes up less space, yet still will seat six, and the chair (l) are folding chairs that can be stored out of the way when not in use. The foods stored are those that can be served without cooking or the addition of other ingredients. These foods are also currently rotated in the normal family consumption so as to prevent the possibility of spoilage and insure freshness.

Medical supplies are stocked, and include not only those things that the family routinely utilizes, but also supplementary supplies and equipment that will be of use in the event of medical emergency in the shelter, or outside the shelter when it becomes safe to venture outside and help others. Entertainment is provided for by the inclusion of books, games, and a wind-up record player. Contact with the outside world will be possible by means of the battery powered portable radio that has a suitable antenna for reception within the shelter area.

Disposal of body wastes will be possible by using the emergency toilet facilities (e, Figure 1), that was made by burying a terra-cotta sewer pipe in the floor. This has a sand bottom to absorb the liquid, and is fitted with an air-tight top to curb the spread of odor. Finally, home radiation measuring instruments are provided so that the radiation level inside and outside the shelter can be measured periodically, and thus indicate when it will be safe to leave the shelter area.

Summary

The successful rebuilding of this nation after thermo-nuclear attack may well depend on the number of the members of the medical and allied-medical professions that survive the effects of such attacks. We have seen that survival of the initial effects of these weapons (blast and heat), means only that one is then faced with the survival problem of the third effect—RADIOACTIVE FALLOUT. Further, it has been pointed out that shielding against the penetration of Gamma rays is the best means of escaping the lethal results of the fallout. Shielding is most adequately provided by a fallout shelter. Therefore, those of us who are going to be in the best position to be "present and accounted for" have, are, or will analyze the situation in view of his own requirements and resources, and then take the necessary remedial steps. Have YOU done this? Will YOU be there after "That Day?"

CONFERENCE ON OBSTETRICS, GYNECOLOGIC AND NEONATAL NURSING

Physicians and nurses from Pennsylvania, New Jersey, Delaware and neighboring states will be taking part in a Conference on Obstetrics, Gynecologic and Neonatal Nursing to be held October 11-12, 1961, at the Penn-Sheraton Hotel, Pittsburgh Pa. The Conference is sponsored by District III of The American College of Obstetricians and Gynecologists, 79 West Monroe Street, Chicago 3, Ill.

PSYCHOTHERAPEUTIC MANAGEMENT OF ACUTE MYOCARDIAL INFARCTION*

• **In the art of effective treatment of acute myocardial infarction, the author reminds us that intelligent psychologic handling is an important part of treatment. It is unrealistic to think of any man being a good physician without first being a warm human being.**

ANTHONY R. TORTORA, M.D.

The medical aims of treatment in acute myocardial infarction is directed towards (a) relief of pain (b) reduction of cardiac work load (c) prevention in spread of the infarct (d) treatment of shock and heart failure (e) treatment of arrhythmias (f) prevention of embolic phenomena.

These aims are accomplished by physical, pharmacological and psychological means. The physical and pharmacological methods are adequately covered.[1-7] The psychological will be discussed in this paper.

Of Deep Concern

Psychotherapeusis, the subject of emotional re-assurance should be a matter of deep concern to us. Particularly is this true for patients with acute myocardial infarction.

The physician's skill and judgment as well as an understanding of the vagaries of human behavior, are required to achieve optimal results.

The virtual epidemic of acute myocardial infarction which has prevailed in this country, the publicity given to former President Eisenhower's "coronary" attack as well as the publicity given to notables of every walk of life who have been victims of "coronaries," has evoked almost infinite discussion of the various facets of this clinical entity in both professional and lay publication since Herrick's classic report.[8]

Concern about the body, a normal and healthy part of growing up, has been exaggerated to a morbid degree, perhaps inadvertently, by mass media. Is it any wonder that the spector of a heart attack creates blind terror in the patient's mind. The attack produces fear and this supplies the "trigger" for the unleasing of anxiety and other emotional manifestations.[9]

Anxiety in its various forms is the most common psychologic manifestation to confront the attending physician who is treating acute myocardial disease.

No organ of the body is more susceptible than the heart to neurogenic and emotional assault. The tendency of anxiety to aggravate the course of acute myocardial infarction is well documented.[10-14]

The heart is an organ which is highly sensitive to emotional excitement. There exist but few individuals who can claim an immunity from this susceptibility. A long continued period of even mild anxiety ren-

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Dr. Tortora, is a Fellow, Academy of Psychosomatic Medicine, Associate Fellow, American College of Cardiology and Assistant Attending Physician, Coney Island Hospital.

ders the heart irritable, and liable to become even more excited under a relatively slight excess of emotional feeling. In cardiologic, as well as in other problems of medicine, the physician must be alert to the basic fact that all human beings possess an emotional equipment which is an integral part of their physiologic function, and which at times may dominate the whole situation. So it must be kept in mind that the human relationship is important in the treatment of patients with myocardial infarction.

The psyche plays an important symptomatic role. Through the psyche, desirable and undesirable effects upon the course of the disease may be enhanced or induced.[15] It must be evident to the attending physician that the psychic problem induced by concern over the attack may outweigh the actual severity of the infarct. Emotional rest depends a good deal upon the attitude of the doctor, who must very definitely inspire confidence from the onset.[16] A physician's dour look or mode of delivery of the facts of the case may induce in a nervous patient, enough fear to bring on a psychosomatic illness. A reassuring statement such as a "myocardial infarction" (heart attack) is quite like a broken arm it heals, is valuable therapy in treating the fearful coronary patient. An uncertain, indifferent, or obviously alarmed doctor does not inspire confidence which is necessary to offset the psychologic shock. The patient's faith in his own future welfare is not enhanced by a medical practitioner who is ostentatiously busy, or who wears a "funereal air of wisdom."[17]

The Wrong Kind Of Fear

There is a level of fear and anxiety which is entirely normal and which indeed may be useful since it motivates patients to adhere strictly to the regimen laid down by the physician. However, there is a form of anxiety which is of such intensity as to interfere with or aggravate the course of the myocardial infarction.[18,19,20] It is this form of anxiety that one must constantly watch for so that all the knowledge in the psychotherapeutic armamentarium can be used to arrest, neutralize and possibly eliminate it. The first concern above everything else is to continue to survive and a heart attack constitutes a threat to survival. The patient will be markedly apprehensive in regard to the outcome of his attack; and will be in great terror and believe this attack signifies the end of things socially, financially, physically and sexually.

Insight Plus Understanding

It is important that the physician clearly show concern by a close, kindly and understanding attention. This includes careful attention to what the patient tells him. If the physician shows the simple human patience this requires, and if he possesses a professional confidence that his knowledge and insight into human behavior will add something of value to the patient, the initial step toward effective medical treatment has been accomplished. Everyone has a highly emotionalized concept of themselves as a functioning individual. One of the most important determinants of the emotional complex that makes up the doctor-patient relationship is the fact that the patient is dependent on the physician for help. Just as the physical growth of the organism depends on an adequate and balanced supply of appropriate foodstuffs, so does emotional growth rely upon the proper psychologic nutrients. Emotions have the capacity to exert influence and thereby change behavior. There is a period in life of entire dependency on others, that is during infancy and early childhood. Since the attack of myocardial infarction and the process of seeking aid from the attending physician represents a reenactment of this stage of dependency, it is only natural that many difficulties, feelings and behavioral reactions met with during the early childhood of the patient will be revived and unconsciously brought to the surface during the doctor-patient relationship.[21] During illness, emotional and behavioral regression may occur. The physician must be aware of this "psychologic" regression since it represents the recurrence of the dependency aspects of the early child-parent relationship.

The Uncertain Future

No problem can be more distressing than that presented by the patient with acute myocardial infarction who feels that death or chronic invalidism is inevitable. What is the proper attitude and approach? I am certain that physicians have pondered over this question. There is no hard fast rule. Many variables influence the decision, among these are the severity of the infarct as well as the personality and background of the patient. Other factors are external circumstances such as his own desire and character, the wishes of his family, his religious connections and his state of affairs. How much patients are to be told is an individualized prescription. The physician is not really concerned with teaching the patient the "physiopathologic" picture of the infarction, but in attempting to let him pass through the phase of incapacity with a minimum of anxiety and a maximum of hope and courage. It should be mentioned that the proper approach should be one of optimism and perseverance. The decision as to whether or not to discuss the exact extent of the attack depends as mentioned on complete understanding of the patient's personality. They can be helped immeasurably with the right kind of reassurance, and this should be given when the patient is prepared to receive it. The next of kin is usually told the exact truth. This may be modified depending upon the patient's role, i.e., if the patient is the pivotal character on which the family revolves. If so, the family or next of kin may well break down if given information more than they can absorb at that one time. They may have to be fed piecemeal as they adjust to changing events.

Early in the acute phase of the attack, as soon as the period of pain or dyspnea and the emotional responses occurring at the onset have abated, the patient becomes anxious about the effects he may expect from his illness. He may express this by asking questions such as, "Is it serious doctor?" "Will I be all right?" Simple as these questions or queries may first appear, they usually signify underlying apprehension. Quite often physicians who are not geared to psychosomatic orientation and awareness, feel that a few words of encouragement or cheer that they give their patients should be enough to minimize their fear and anxiety. The spoken word is only part of the approach. It is not sufficient to merely tell the patient he is improving. He must be made to feel it.

When the patient feels a positive assurance that he is in safe and understanding hands, the sense of security benefits his vegetative nervous system.[22]

Superficial Psychotherapy

Most initial anxiety reactions respond to superficial psychotherapy. Psychotherapy may be defined as an attempt to influence the attitude of the patient in the right direction, to influence the attitude toward himself and toward his mental and physical processes. Whether this avenue of approach will consist largely of cooperation and mutual understanding or of persuasion or suggestion will depend not only on the convictions of the physician, but also, perhaps chiefly, on the needs of the sick individual. The astute physician will discern this need quickly and will find an expedient way to give rapid guidance and support.

For the doctor-patient rapport to be effective it must be based partially on a certain amount of confidence and respect on the part of the patient. At first, however, this is not too important, since the patient will accept any helping hand. He is obsessed with anxiety, unable to think of anything else, even though he may be highly intelligent. But he is totally unable to utilize his intellect to control his anxious state.

Psychopharmacotherapy may have to be used to help control the emotions and to enhance the receptivity of the patient.

It must be stated emphatically that normal emotivity is to be expected, and it is not desirable or necessary to expect a complete loss of emotivity. The emotion is a reaction to disaster, a recoil. The patient

comes out of his stunned state and must face a life altered by this catastrophic event.

However, the emotional reassurance as a therapeutic modality, the patient can be helped to work through the recoil with a minimum of aftermath.

Psychotherapeusis is a positive action; the goal of which is to get the patient in a healthy optimistic state of mind, so that he may return to society as an independent creative member.

Treatment and management of acute myocardial infarction is incomplete without psychologic emotional reassurance. What is contributed by reassurance spells the difference between a discouraged misfit in society and a well-adjusted patient living within confines of his cardiac reserve.

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GRADUATE COURSE IN MEDICAL HYPNOSIS

A graduate course in medical hypnosis is being offered to physicians and dentists by the University of Pennsylvania Graduate School of Medicine to be given at the Institute of the Pennsylvania Hospital, 111 North 49th Street, Philadelphia, Pennsylvania.

There will be 24 weekly afternoon sessions beginning October 4. This year's course has been expanded from 72 hours to 96 hours.

It is, at the present time, the only course offered which meets recommendations made by the American Medical Association's Committee on Hypnosis.

During the first part of the course, basic concepts of hypnotism will be taught through lectures on psychiatry and hypnosis, demonstrations, and supervised prcatical work in hypnosis.

The latter part of the course will cover clinical applications of hypnosis. Here there will be sessions limited to psychiatrists and other sessions limited to general practitioners, dentist, and specialists other than psychiatrists.

A TECHNIQUE FOR BRONCHOGRAPHY
With Oily Dionosil

• **The simplicity of the technique outlined in this article gives bronchograms which have excellent definition outlining the bronchial tree and accurately locate diseased areas. Dionosil Oily has the further advantage of being rapidly absorbed and excreted thereby rendering the patient's x-rays clear of the opaque medium in a few days.**

NORA O'FLYN O'BRIEN, M.D.

Dionosil[1] is a suspension of n-propyl ester of 3: 5-diiodo 4 pyridone N acetic acid (propyliodone) and is the medium used.[2]

Postural drainage is carried out for 15 minutes before the patient is given premedication. Patient is fasting for the preceding 12 hours. A short acting barbiturate (Seconal 1½ gr.) and atropine sulphate 1/150 grain (h) are given one half hour before the procedure.

Sensitivity Tests

Degradation does not extend to the liberation of iodine which might give rise to sensitivity reactions. Patients sensitive to iodopyracet may also be sensitive to Dionosil and hence should be tested.

Anaesthesia Of The Bronchial Tree

Pontocaine 2% is used to spray the pharynx and larynx. On the average 7 ccs. of pontocaine are used. The tip of the patient's tongue is wrapped in gauze and the tongue held out by the patient while the pharynx and larynx are sprayed with 2% pontocaine. The patient is instructed not to swallow this solution but to expectorate any secretions in the throat and mouth at intervals during this anesthethising period. The patient sits up and inclines forward with the chin extended. A rubber cathether, refrigerated and adequately lubricated is inserted through the nostril down to the larynx. The extended tongue is held by the patient while the cathether is passed into the trachea and towards the carina. A #12-18 rubber cathether is used depending upon the size of the larynx. About 2/10 of a cc of pontocaine is injected into the lumen of the cathether and the patient is instructed to lean to the side that is to be filled. Usually the patient may cough a little after the insertion of the tube and pontocaine. The upper end of the cathether is strapped to the patient's cheek. The patient is then instructed on the different body positions required and a dry run is made.

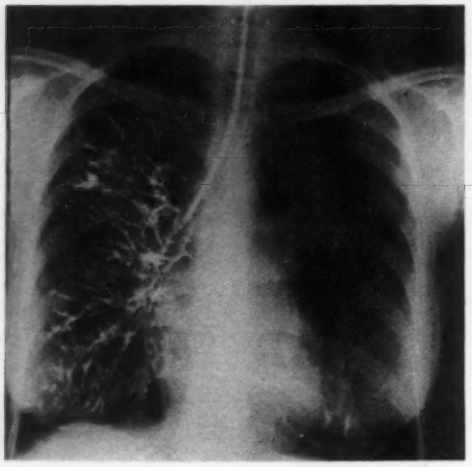
Introduction Of Medium

The patient is told to take a deep breath just prior to the injection of some of the

Dr. O'Brien, National University of Ireland, '42, was previously staff physician to Middlesex County Council and Harefield Hospital, Middlesex, England; has been staff physician at Emily P. Bissell Hospital, Wilmington, since 1950 and became a U. S. citizen in 1957.

REFERENCES

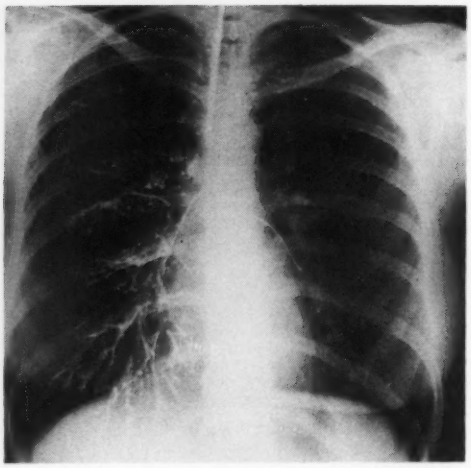
1. Dionosil is distributed in the United States by Picker X-ray Corporation.
2. Chemically, the n-propyl ester in Dionosil is closely akin to iodopyracet which is the disthanolamine salt of the same iodine — containing organic acid. In a few days the ester is completely hydrolyzed, absorbed into the blood stream and excreted in the urine.



Case 1

20 year old woman, white, patient. Tuberculin skin test negative, sputum and gastric series negative for AFB on concentrate and culture.

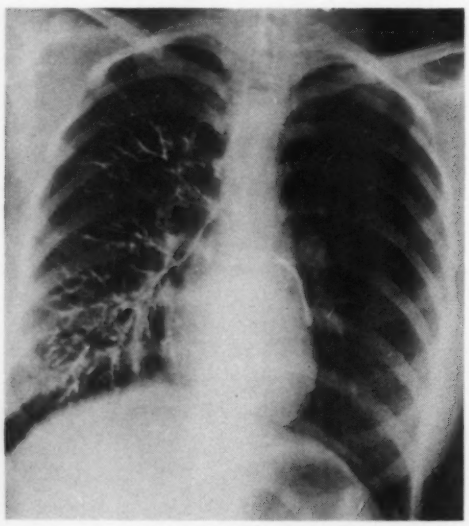
Bronchograms demonstrate saccular bronchiectasis in the right upper lobe and left lingula and lower lobe. Surgery was not carried out in this case because of the extent of the area involved.



Case 2

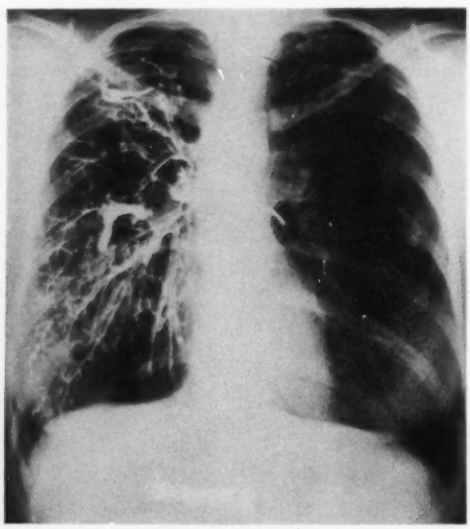
25 year old woman, white, patient. Tuberculin skin test negative, histoplasmin skin test positive. Gastric lavage series AFB culture negative.

Bronchograms demonstrate the filamentous type of bronchi associated with emphysema.



Case 3

15 year old woman, white, patient. Tuberculin skin test negative. Gastric lavage series negative AFB culture. Bronchograms demonstrate normal bronchial tree.



Case 4

27 year old woman, white, patient. Diagnosis of far advanced, active pulmonary tuberculosis, with resistant type of AFB to SM, PAS and INH combination.

opaque material, to hold the breath while the material is being injected, and then to exhale gently. This latter exercise has to be repeated until all of the opaque material (approximately 18 cc. to 20 cc. for an adult to fill one lung) has been inserted.

During the injection of the opaque material the patient lies supine with the head on one pillow and the contra lateral shoulder raised from the table.

When the opaque material has been inserted, the patient assumes the prone position on the table for 30 seconds and returns again, but this time to a full supine position for 30 seconds. He then stands and has PA lateral and oblique films taken.

The time limit from the beginning of the instillation of the Dionosil Oily to the first x-ray is three minutes, otherwise there is alveolar filling.

The patient then has postural drainage for 15 minutes after the procedure, although the material is readily absorbed and excreted.

The illustrated cases demonstrate the satisfactory bronchograms obtainable with Dionosil Oily. The bronchial tree is well outlined and the diseased areas are located accurately.

Dionosil Oily is used in tuberculous cases under effective antimicrobial therapy and there has not been any evidence of exacerbation of disease following its use. The rapid disappearance of this vehicle from the lung is also one of its main advantages.

Sputum converted AFB negative on Viomycin, INH and PAS combination. Bronchograms demonstrate cavities in the right upper lobe and in the superior segment of the right lower lobe. Patient had a right upper lobectomy and wedge resection of the right lower lobe. X-ray: post operative, demonstrates the re-expansion of the right middle lobe and the remainder of the right lower lobe.

Summary

The use of more elaborate techniques for positioning the patient such as tilting tables have been used by me, but the results have not been as good as with the simple procedure outlined above.

I wish to thank the Supervisor of the X-ray Department, Mr. Robert Holland and his assistant, Mrs. P. Bowers, also Mrs. E. Daily, Clinic Nurse, for their co-operation in carrying out these studies.

POSTGRADUTE COURSE

A Postgraduate Course on *Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs*, sponsored by the American College of Chest Physicians, will be held at the Park Sheraton Hotel, New York City, November 13-17, 1961. The same course will be given on December 4-8, 1961 at the Statler-Hilton Hotel, Los Angeles, Cal. Registration for the course may be made in advance by writing the A.C.C.P., 112 East Chestnut St., Chicago 11, Ill.

PUBLIC HEALTH ASPECTS OF READY-TO-EAT FOODS

• **The following article presents a literature survey, an extensive bibliography and a bacteriological survey of commercially prepared salads offered for sale in the Chapel Hill-Durham, North Carolina area. Data is presented which substantiates the methods and procedures used.**

RICHARD B. HOWELL, III, B.S.

Modern day supermarkets are filled with a variety of convenience foods. One of the most recent additions is the commercially prepared prepackaged salads and sandwiches. An idea of the scope and growth of this industry is given by Food Engineering[1] which states in 1960 ready-to-eat food sales were $3.7 billion and are expected to reach $4.6 billion by 1965. A considerable portion of this growth is undoubtedly a direct result of the rapid growth of the commercial salad industry.

Health departments spend a great deal of time exerting surveillance over the canning and milk industry, and with the cooperation of industry have greatly reduced the incidence of food-borne disease and infection attributed to these foods. When records of other food-borne disease outbreaks and cases are examined such a degree of achievement is not in evidence. There is no implication here that food-borne disease reporting is adequate, rather, many investigators have decried the lack of information in this field.[2,3,4] There is evidence, however, that once a problem is recognized action is taken to alleviate it.[5] Many authors have cited the potential danger of food-borne disease outbreaks arising from ready-to-eat uncooked food of which salads are a notable example.[2,3,4] Considerable concern has been voiced by health authories regarding conditions of manufacture and distribution of the products.

Let us assume that conditions are such that the problem is recognized. In order to plan for effective action, the following questions must be answered:

1. What action is to be taken?
2. What are the methods and procedures of sanitary inspection?
3. Are microbiological standards to be used, and if so, should they be legal or administrative?
4. Are standard methods available or can they be adapted to this product?
5. What organisms are to be used as indices?

The questions posed here are very broad and will necessarily be dependent upon actual conditions. However, it is believed a few short answers are in order. Sanitary control of an industry depends on adequate knowledge of that industry; knowledge of the basic principles of sanitary science; and an acceptance and awareness of the value and need for sanitation by the leaders of industry. Sanitary inspection must be carried out by competent personnel who are well-versed in sanitary practices. Particular attention must be given potential sources of contamination, including raw materials as well as construction and cleaning

Mr. Howell, M.P.H., is Consulting Sanitarian, Division of Sanitary Engineering State Board of Health.

TABLE I

TYPE AND BRAND DISTRIBUTION OF PRODUCTS

Samples	*Total*	*A*	*B*	*C*	*D*	*E*	*F*	*G*
Chicken salad	11			7	1	2		1
Egg salad	5	1		2	1		1	
Potato salad	3					2		1
Ham salad	7	1	1	1	1	1	1	1
Cole slaw	3					2	1	
Pork barbecue	1			1				
Total	30	2	1	11	3	7	3	3

equipment, time and temperature relationships, and personal hygiene of workers. Microbiological standards are desirable as indices of plant sanitation. They are advocated here as an adjunct to adequate sanitary surveillance, not a substitute for it.[2,3,4] To be effective in most food processing industries, standards should be of an administrative nature. Methods for microbiological examinations of these foods can be adopted from these currently used by the shellfish industry, and those recommended for the frozen food industry. [7,8,9] Coliform group and undifferentiated plate count[10,11,12,13,7,8] are applicable to these products.

Bacteriological Study

A bacteriological survey was made of prepared salads offered for sale in the Chapel Hill, Durham, N.C. area, between February 10, 1961 and April 4, 1961.

Packages of the products, representative of these sold in the area, were purchased at random from stores and supermarkets. They were taken immediately to the laboratory where they were examined.

Laboratory Procedure

Portions of the sample from different parts of the container were removed with a sterile spoon, and 50 grams weighed in a sterile tared petri dish. The weighed portion was tranferred to a sterile waring blender cup containing 450 ml of sterile phosphate buffer solution.[8] The mixture was blended at low speed for two minutes, the blender stopped and the mixture allowed to stand for one minute to allow entrained air to escape.[14,15,16] Standard undifferentiated) plate counts (SPC) were obtained using MPH Agar. [8,17] Coliform group organisms were determined using Violet Red Bile Agar (VRB), according to the procedure of Hartman[10,11] and Kerelak and Gunderson.[13]

For the purpose of this report the definition of the coliform group as stated in *Standard Methods for the Examination of Water and Waste Water*[17] and *Standard Methods for the Examination of Milk and Milk Products*[18] will prevail.. (Since the foods involved are eaten "as is," i.e., they normally are not subjected to conditions or methods of preparation which would be lethal to members of the coliform group.) This group is used as the index organism of choice.[6]

Laboratory Results

Six different types of salads, manufactured by seven different companies, or thirty (30) samples, were examined with distribution as shown in Table I.

Results of the bacteriological study will be found in Table II and III. There is no

TABLE II

COMPARISON OF BACTERIAL CONTENT BY PRODUCT

	Number		*SPC*			*Coliform*	
Salad	*Samples*	*low*	*high*	*median*	*low*	*high*	*median*
Chicken salad	11	3,000	3,000,000	40,000	1	163	15
Ham salad	7	3,000	3,000,000	12,000	1	1,300	1
Egg salad	5	130,000	5,000,000	160,000	1	500	56
			est		1		
Potato salad	3	8,000	11,000,000	65,000	1	441	105
			est	est	1		
Cole slaw	3	4,000	370,000	10,000	1		1
Total	29	3,000	11,000,000	40,000	1	472	15
			est				

readily apparent relationship between undifferentiated plate count and coliform count nor is there any relationship between either count and type of product. There is, however, a relationship between both coliform content and undifferentiated plate count and manufacturer. This relationship is shown in Table III. Preliminary data shows a good correlation between sanitary conditon of the plant, when measured by the usual techniques, and bacterial count. A more exhaustive examination of this type is desirable to establish the exact limits and significance of this factor.

Conclusions

1. Ready-to-eat foods pose a significant public health problem as revealed by a literature survey, bacteriological data available and opinions of state control officials.[19]
2. A well operated and maintained plant can produce salads with low bacterial content when measured by the coliform groups and undifferentiated plate counts.
3. Coliform group organisms are reliable indices, which may be applied to these foods with the possible exception of those having high acid content as measure by pH (cole slaw, pH 3.8 was the only such product encountered in this survey).[19]

TABLE III

COMPARISON OF BACTERIAL CONTENT BY BRAND

	Number		*SPC*			*Coliform*	
Brand	*Samples*	*low*	*high*	*median*	*low*	*high*	*median*
A	2	130,000	3,000,000	1,600,000	500	13,000	6,750
B	1		5,000	5,000		<1	<1
C	10	3,000	930,000	35,000	<1	202	32
D	3	3,000	160,000	4,000		<1	<1
E	7	4,000	11,000,000	370,000	<1	3,000	<1
			est				
F	3	10,000	5,000,000	37,000	<1	1	<1
			est				
G	3	8,000	2,100,000	12,000	<1	134	1
Total	30						

4. Coliform determination by use of solid media Violet Red Bile (Agar) provides a rapid and economical method, which lends itself to routine control work.
5. A practical method for routine analysis is given.
6. Bacterial standards for these foods are desirable, and in the opinion of the writer should be established at the administrative level and used only after careful interpretation.
7. Bacterial standards should serve as a tool in the armamentarian of official agencies; they are useful as an adjunct to sanitary surveillance, but should never serve to diminish or supplant it.
8. The principles and practices of sanitary surveillance which have been developed in other fields, notably milk, water and shellfish, are readily adaptable to this industry, and when judiciously applied yield excellent returns for the effort expanded.

ACKNOWLEDGMENT

This article was prepared using data obtained for an M.P.H. Thesis at the University of North Carolina, 1961. The author wishes to express his appreciation to Gilbert L. Kelso, Associate Professor of Sanitary Science School of Public Health, University of North Carolina, who directed the preparation for this paper.

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UROLOGY AWARD

The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in Urology. Competition is limited to Urologists who have been graduated not more than ten years, and to hospital internes and residents doing clinical or laboratory research work in Urology. Animal research is not necessary.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Bellevue-Stratford Hotel, Philadelphia, Pennsylvania, May 14-17, 1962.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore 1, Maryland. Essays must be in his hands before November 15, 1961.

BABIES and BREADWINNERS

• **Complete immunization of a high percentage of our population under forty-five years of age is essential for the control of poliomyelitis. A method by which this may be accomplished is described in this article.**

MAYNARD H. MIRES, M.D.

Until May 5, 1961, the State Board of Health had not contemplated holding any more mass polio vaccination clinics. We felt that after our strenuous efforts of the past five years the population was sufficiently protected so that an epidemic of polio in Delaware was most unlikely. On the above date, however, a report on results of the polio immunization survey in Wilmington was given by Dr. James C. Strong, City Health Commissioner. This survey had but recently been completed, and the final tabulations were being made by statisticians at the Communicable Disease Center in Atlanta, Georga.

Divided Into Five Areas

Based on census tract data, the city had been divided into five areas: (1) upper socio-economic, predominantly white, (2) middle socio-economic, predominately white, (3) lower socio-economic, predominantly white, (4) predominantly non-white (upper), and (5) predominantly non-white (lower). Field work was carried out by five teams of interviewers comprised of personnel from the city and county health departments. Each team consisted of a sanitarian from the New Castle County Health Unit staff and either a nurse, inspector or clerk from the Wilmington Health Department staff.

Of 480 scheduled interviews (thought to be a fair random sampling of these five areas), 460 or almost 96% were completed. The objective, of course, was to obtain information on polio immunization status on the first visit to the home. However, 13% had to be contacted later by telephone, and 8% had to be revisited.

Two General Trends

The polio immunization status was tabulated by age groups and by socio-economic area, and two general trends were observed: (1) the higher socio-economic status, and the greater proportion immunized, and (2) in all socio-economic areas, a higher proportion were immunized among school age children than in other age groupings.

Final figures pointed up the fact that the non-white population in Wilmington was less well vaccinated than the white population. The least immunized group consisted, of course, of non-white young adults, where less than 20% had received three or more injections. Surprisingly enough, only about one half of the non-white children of school age had received three or more injections (in spite of the intense immunization program carried out in the schools).

Dr. Strong's report stimulated us sufficiently to once again set up free state-wide clinics with a view to administering two doses of polio vaccine to this poorly-protected group before the "polio season." Our special target, therefore, became the low-income neighborhood . . . that island of

Dr. Mires, M.P.H., is Director of Local Health Services, State Board of Health.

unvaccinated persons within an otherwise well-vaccinated community.

At about this time, the U. S. Public Health Service distributed copies of a plan for the "1961 Neighborhood Polio Vaccination Campaign," and entitled it, "Babies and Breadwinners." This title referred, of course, to those two poorly immunized groups, the children five years and under and the young adults. A study of paralytic polio cases occurring in the United States in 1960 showed them to be the hardest hit.

Crash Programs Developed

At this meeting on May 5th, the Wilmington city health officer and the three county health officers were encouraged to develop their own crash programs to get the job done in their localities. These plans differed somewhat depending on local circumstances, although the objectives remained the same everywhere. The northern part of the State elected, because of its great concentration of population, to make use of the "jet injector" or hypospray gun, two of which had been recently purchased by the State of Delaware. Kent County decided on the mobile unit appproach . . . a bus equipped for vaccinations, parked on busy corners or in low income neighborhoods with help from a roving sound truck. Sus sex County was to depend on nearby clinics, setting up in the heart of a neighborhood, no more than three or four blocks from any resident.

Preliminary discussions with our health educators centered around the apparent apathy and lack of interest shown by the low-income group. We were reminded that there are several reasons why this group has always escaped us: (1) Their lives are so full of problems that the danger of polio seems relatively unimportant, (2) They generally have no family physician to advise them, (3) They tend to distrust "official agencies," and (4) They often have no means of transportation to the regular vaccination centers. For these reasons, our decision to carry the program to the people in Kent County seemed a good one.

Naturally, a necessary first step was to obtain the blessing of each County Medical Society. No public health program can be truly successful without the active support and approval of the physician in the community. As a result of our propaganda, we expected a certain number of the regular patients of family physicians to be motivated to complete their immunizations. Our target group, however, was one not normally reached by private physicians in their offices.

The Division of Health Education of our State Board of Health then set about involving any number of community organizations, obtaining volunteer record-keepers from The National Foundation, contacting local school principals, ministers, newspapers and radio stations. Well-informed school children (most of whom already vaccinated in Kent County) were urged to bring their parents and younger siblings to the clinic location. Everywhere there suddenly appeared posters picturing a very blue and very sad rabbit; "Are you a dumb bunny"? he asked, "Or have you had your polio shots"? Then the message continued, "Be sure . . . Be Wise . . . Immunize! Don't take a chance . . . Take your polio shots NOW!"

Drastic Methods

Some of the methods employed in the campaign would ordinarily be frowned upon as too expensive and time-consuming for the expected results. And yet, finding out who in each neighborhood had "status," and convincing him or her of the role to be played, seemed important if we were to get real local support. We were richly repaid in some locations when these neighborhood leaders let it be known that a good turnout would be appreciated. This was much more effective than the orthodox methods of publicity. As old as mankind's social order, the word of mouth approach is the best.

Kent County's polio vaccination clinic schedule looked rather full when we finished

drawing it up. There were nineteen separate clinic locations to be visited from late May to the end of June, and then the whole circuit must be repeated in July. This necessitated health unit personnel working three extra nights each week for about 2½ months. However, no complaints were forthcoming; everyone realized the importance of reaching these hitherto "unreachable" people and keeping our polio slate clean. Futhermore, there was a certain feeling of excitement as we watched the banners go up on the sides of the great white bus, proclaiming "Free Polio Shots Here." We might go so far as to say that there was a keen spirit of competition shown among the public health nurses, each one hoping that her district would have the greatest turn-out!

After only a few of these mobile clinics, we began to form our own impressions of the type of response we were getting; mostly first and fourth shots to young adults and children (both pre-school and school age). It may be of interest to give a few percentages for the first month of operation: 31.5% of the shots were first injections, 6.5% were second, 10.0% were third, and 52.0% were fourth. (Percentages have been rounded off for purpose of this presentation.)

In the few words of conversation we had with various individuals as they came on the bus, we learned some of the reasons why they had not taken advantage of this before. These statements from supposedly intelligent adults showed how little our teaching had been absorbed: "I thought if you took these shots after 35 they might hurt you." "I thought these shots were only for kids." "I lived through a polio epidemic once and didn't get it, so I must be immune." "I was told that if I once started the shots and didn't finish, I'd be in serious trouble."

Nevertheless, despite these little misunderstandings, the "Babies and Breadwinners" did come to our special clinics after all. The actual figures cannot be given as part of this article, because, at the time of writing, we have not yet completed the second part of our circuit. We feel, though, that the program is accomplishing its objective; to stimulate vaccinations of young children and young parents, particularly in the low-income areas. The mobile unit type of operation has a distinct advantage in bringing the service directly to the neighborhoods that need it the most.

ACKNOWLEDGMENT

The author is indebted for assistance in writing this article to Dr. James C. Strong, Wilmington City Health Officer, and to Mr. Jerome D. Niles, Director, Division of Health Education, State Board of Health.

"PROBLEM OF ALCOHOLISM IN THE PRACTICE OF MEDICINE"

To advance the understanding of the Problem of Alcoholism in General Practice, the Committee on Nutrition and Metabolism, Philadelphia County Medical Society, jointly with the Division of Behavioral Problems, Department of Health, Commonwealth of Pennsylvania and the National Vitamin Foundation are sponsoring a Symposium on the Problem of Alcoholism in the Practice of Medicine. This Symposium will be held on October 30, 1961 at the College of Physicians of Philadelphia, 19 So. 22nd Street at 2:30 P.M.

Acceptable for Category II credit of three hours by the American Academy of General Practice.

Short-Term Therapy In ACUTE MUSCLE AND JOINT DISORDERS

ROBERT SEEHERMAN, M.D.

Although often regarded as one of the less demanding therapies that the practitioner is called on the provide, the treatment of acute muscle and joint disorders does present its own peculiar problems. Since the symptoms may have arisen from any of a variety of underlying conditions (very often from several at once), the chances are usually but slight that improvement of the underlying condition itself can be obtained in a few days. Nevertheless, the patient expects relief of his symptoms in a few hours or, at most, in a few days. Unless such prompt relief is forthcoming, the physician may not get a chance even to initiate definitive therapy of the underlying condition, for some patients will consider the symptomatic treatment a failure after only a few days and give it up.

In this context, a clinical trial of carisoprodol* was made in patients with acute or traumatic muscle and joint pain and stiffness. Carisoprodol is a recently introduced agent, reported to have pain-relieving effect as well as muscle-relaxant action[1,2] and effective.[5,6] These qualities would make the drug particularly useful in office practice. It is available in 350 mg. tablets and 250 mg. capsules. Except in two very young patients (aged 10 and 11 respectively) the tablet form was used throughout this trial.

Method

Seventy-one patients, of whom 42 were female and 29 male, were given carisoprodol in this trial. Ages ranged as follows:

10-25	10	36-50	32
26-35	20	over 50	9

The unusually large proportion of patients in the lower age groups is due to the inclusion of traumatic injury cases.

Dosage in all except three adult patients (and the 10- and 11-year-olds) was one, 350 mg. tablet q.i.d., often reduced to p.r.n. dosage after the first few days. In the three excepted cases, a lower dosage was used; in one of these (torticollis), two tablets h.s. were prescribed to promote sleep.

Concomitant therapy included heat, physical therapy and manipulation where indicated, traction (one case) analgesics (10 cases) and ethyl chloride spray (four cases).

Duration of therapy was typically short-term, ranging from two to 10 days and averaging about one week. Lack of results in this period was rated as a treatment failure.

Results

Results were classified as excellent (full orpractically full relief of symptoms), very good (great relief of symptoms), good (substantial relief of symptoms), fair (some relief), and ineffective. Patient reports and clinical observation were the basis in assessing results; pain is so subjective and variable that attempts at objective measurement were deemed impractical in this investigation. Symptoms evaluated for intensity were muscle pain, joint pain, muscle spasm and stiffness, limitation of motion, rigidity and, where present, tension, irritability, and insomnia.

Results are detailed in Table I. Twenty-three patients had excellent results, 24 very good, 8 good, 9 fair; in 7 patients treatment was ineffective. This rate of effectiveness for carisoprodol (68% excellent or very

Dr. Seeherman is Associate in Medicine to the St. Francis, Memorial, Delaware and Wilmington General Hospitals.

*Carisoprodol was supplied as Soma by Wallace Laboratories, Cranbury, N. J.

TABLE I

Indication	*No.*	*Ex.*	*V. Good*	*Good*	*Fair*	*Ineff.*
Lumbo-sacral, sacroiliac strain	29	9	12	1	5	2
Myositis, bursitis, fibrositis, torticollis	30	12	6	5	3	4
Osteoarthritis, arthritis, periarthritis	6	—	3	1	1	1
"whiplash" injury	2	—	1	1	—	—
Sciatica	1	1	—	—	—	—
Strain, sprain	2	1	1	—	—	—
Disc syndrome	1	—	1	—	—	—
TOTAL	71	23	24	8	9	7

good) is considered highly satisfactory, particularly in view of the short duration of therapy and the relative freedom from side effects.

Side effects consisted of 14 cases of mild drowsiness (including one on placebo used experimentally early in the investigation), one case of moderate drowsiness, one case of dizziness, and one case of "heartburn."

Therapy was discontinued in only one patient—a 41 year-old male with bursitis. In this case, development of lethargy indicated discontinuance of medication (carisoprodol and Dextro-Propoxyphene Hd) although the presenting symptoms had all diminished in degree from severe to mild.

Discussion

Prompt and safe results in the treatment of office patients incapacitated by pain and stiffness associated with muscle and joint conditons are important to the therapy of the underlying conditon. In this study, carisoprodol showed a good rate of effectiveness in relieving muscle and joint pain and stiffness, sometimes in hours and usually in a day or two. In addition, other drug therapies required were unaffected by this agent, and in many cases, manipulation and physical therapy were made easier and more acceptable to the patient. In addition to relief of muscle and joint pain and stiffness, relief of irritability and insomnia were noted, probably as a result of the easing of pain. The occasional occurrences of mild drowsiness did not prove to be a serious handicap; indeed, in retrospect, it would appear to be a good idea to increase the h.s. dosage routinely to two tablets as an aid to sleep—often a problem in patients with muscle and joint pain.

Summary

In a study of 71 patients with conditions involving muscle and joint stiffness and pain, carisoprodol was administered (350 mg. q.i.d.) for a period of about one week.

Results were classified as excellent in 23, very good in 24, good in 8, fair in 9, and ineffective in 7 patients.

Side effects were limited to drowsiness, usually mild, one case dizziness, one case of "heartburn," and one case of lethargy.

There were no effects noted on blood, endocrine, renal or hepatic systems; no tolerance or withdrawal effects were encountered.

Carisoprodol proved to be effective and free from serious sife effects in this study of short-term treatment in conditons involving muscle and joint pain and spasm.

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Editorials

DOCTORS AND "SOCIETY"

"The practice of medicine is a public trust," Secretary of Health, Education and Welfare Abraham Ribicoff told the graduating class of the University of California Medical Center this week.

Has any young man or woman on the threshold of a medical career thought otherwise?

"Each of you in your two decades of training thus far has been heavily endowed by the people of your community, your state and country," Mr. Ribicoff continued.

Has any fledgling physician ever disputed that fact?

"Nor will the public interest in you end when your education is completed . . ." the Secretary said. "Public laws will govern your practice. The hospital in which you work will be licensed by the public and may well have been built or equipped with public funds."

Those statements are elemental, as every graduating doctor in the land knows full well. But then Mr. Ribicoff turned to the realm of forecast. He said:

"In a few years you will come into your own as full-fledged practicing physicians. The new world that is yours to serve will be very different from the world as it was when you began your long preparations . . . The very texture of our society will be different."

What did the Secretary of Health, Education and Welfare mean by that? Did he mean that doctors of the future will have to adjust themselves to the Big Brother "texture of society"? Did he mean that because the public has taken a deep interest in the education of its doctors and has supplied some funds to build hospitals, medical graduates should feel obligated to consider themselves servants of the state, and beholden to some socialistic bureacracy in Washington?

If that's what Mr. Ribicoff meant, we hope, with a considerable degree of confidence, that every young man and woman, now and in the future, who has the savvy to earn a degree in medicine will also have the courage to say to him nay.

Reprinted from the Omaha, Nebraska World-Herald.

THE TEXT OF THE MATTER

Elsewhere in this issue is an article entitled "Psychotherapeutic Management of Acute Myocardial Infarction" by Doctor Anthony R. Tortora. The text appears in three sentences about the beginning of the last quarter of the article. "*The spoken word is only part of the approach. It is not sufficient to merely tell the patient he is improving. He must be made to feel it.*"

There undoubtedly will be critics who claim that there is nothing new in Doctor Tortora's article. Regardless of whether or not there is anything new, the truths contained therein are of such importance that they need retelling. We have repeatedly urged physicians to act as they speak; do not tell the patient that he has nothing to worry about, then give medicine and tell him to "take it easy." Doctor Tortora's article is important and timely.

"When Should My Cardiac Patient Return To Work"? by Doctor C. Anthony D'Alonzo appears in the August 1961 issue of *Medical Times*. Doctor D'Alonzo presents a down-to-earth and knowledgeable discussion of this most important subject. Although industry usually allows three months for convalescence from an acute heart attack, there is nothing magic in this number and we must individualize our thinking along these lines according to the factor in each case.

These two articles present logical thinking about a most common and important problem. It is hoped that some of our readers will be led to consult *Medical Times* for August 1961.

In Brief

Delaware Hospital's New Laboratory

A new laboratory has been opened in the Delaware Hospital, Wilmington, to perform a thyroid test possible until now only in large medical centers. Developed to determine the amount of protein-bound iodine in blood serum, the laboratory's method of using radioactive iodine to check all stages of the procedure was developed by the Atomic Energy Commission at Brookhaven National Laboratory. The new laboratory was placed about 600 feet from the hospital to avoid possible contamination from drugs containing iodine. Its diagnostic service is available to physicians in hospitals here and in nearby states.

Insect Sting Data

Careful records of the natural history of bee, wasp, yellow jacket and hornet stings—with particular reference to anaphylaxis, as observed by the physician—are being compiled by the American Academy of Allergy. In order to accumulate this data, members of the Medical Society of Delaware are urged to report cases so that they can be recorded and follow-up observations made. Please notify: Leonard S. Girsh, M.D., American Academy of Allergy, Representative, State of Delaware, 3701 N. Broad St., Philadelphia 40, Pa.

Physicians Take Note

In a recent letter to your president, Dr. Lemuel C. McGee, the National Foundation asked that member physicians be reminded that it does not reimburse them for personal professional services in the care of patients with acute and residual paralytic poliomyelitis. This policy, which became effective in 1959, permits assistance to families of private as well as non-private patients without involvement in the traditional patient-physician relationship, and without concern in the matter of physician's and surgeon's fee. The National Foundation believes that its assistance to families afflicted with such chronic diseases should be available to *all* who might suffer severe economic hardship from such an event.

New Paternity Clues

Conformity of the ridges of each finger between alleged parent and child is a more reliable sign of paternity than various other anthropologic measurements, according to Professor Sandor Okros, speaking at the 5th Congress of the International Academy for Legal and Social Medicine in Vienna. His conclusions, based on a 14 year study of more than 1000 families in whom there was no doubt about paternity, definitely establish the reliability of using the arrangement of the external ridges of the skin at the fingertips to establish paternity.

Public Relations Tip

One of the biggest brickbats thrown at the medical profession, is the old one—'As soon as the doctor finds out his patient has insurance, he immediately increases his fee.' "It should be perfectly obvious," says Edward H. Crane, Jr., M.D., President of the Los Angeles County Medical Association, "that if the fee is set before the insurance coverage is mentioned, there will be no foundation for this irksome criticism. Discuss the fee first—insurance, second."

Personal Glimpses

John C. Rawlins, M.D., has been named president of the Board of Education of Seaford's special school district; beginning his fourth year as a member of the Board . . . George Botte, M.D., has been named acting superintendent of the State Welfare Home and Hospital for Chronically Ill at Smyrna to fill the vacancy created by the death of Clarence J. Prickett, M.D. . . . Drs. Leonard P. Lang, Frank T. O'Brien, and Peter R. Walsh of Wilmington were certified as new Fellows of the American College of Chest Physicians at its 27th Annual Meeting . . .

Executive Job Hazards

At a recent meeting of the American College of Physicians, Lemuel C. McGee, M.D., urged executives to engage regularly in recreation and to develop wholesome living and working environments to avoid frustration. He listed the major occupational hazards as: the cocktail hour, excess banquet food, boring afternoon speeches, the swivel chair, stress in dealing with people in everyday living, and decision making.

Nibbling vs Meal Eating

Studies made on body metabolism in chickens found that the manner of food intake affects the production and regression of the cholesterol level of the blood, reports *Circulation*. The induction experiment showed the "meal eaters" exhibited twice the serum cholesterol levels and seven times the severity of coronary atherosclerosis seen in "nibblers."

Increased Emphasis On Prenatal Factors

The support of the following two senate bills, emphasizing factors affecting a child before its birth, has been advocated by Nicholson J. Eastman, M.D., president of ACOG. (1) Senate Bill No. S 2269, establishing the Institute of Child Health and Human Development and the Institute of General Medical Sciences, as new divisions of the National Institutes of Health and (2) Senate Bill No. S 2273, authorizing research grants for maternal and child health.

Live Dangerously?

A "new look" at older persons, particularly those with chronic disease, is advised by Alvin L. Barach, M.D., Emeritus Professor of Clinical Medicine, Columbia University, NYC, who deplores the adage "conserve the energies of older people." Dr. Barach believes that idleness breeds unhappiness, boredom contributes to poor health; that an apparently peaceful life may foster tension and anxiety. He emphasizes that work has a beneficial effect on body, mind and soul. *Journal of the American Geriatric Society, July, 1961.*

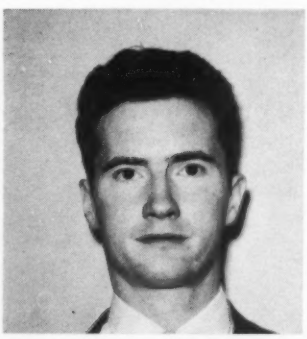
Medical Examiner Aides

Appointments of 17 deputy medical examiners have been announced by Philip J. G. Quigley, M.D., State Medical Examiner. Dover: Drs. Charles Allen and Norman P. Jones; Milford: Drs. Clarence E. Graybeal and John W. Annand; Millsboro: Drs. A. L. Czebotari and Virgil A. Hudson; Rehoboth Beach: Drs. R. L. Klingel, E. L. Stambaugh, and Carl G. Pierce; Bridgeville: Dr. R. H. Beckert; Seaford: Drs. J. Leland Fox, Robert C. Kingsbury and John C. Rawlins; Laurel: Dr. Charles M. Moyer; Midletown: Drs. Harry L. Hoch and Demeter Skrypec.

New Members

George C. Ginter, M.D., Hahnemann Medical College, '54, lives in Glen Mills, Pa.—his native state. Dr. Ginter has three children and his hobbies are gardening and Hi-Fi. Delaware license: 1959. Specialty: Anesthesiology. Office: Memorial Hospital.

Samuel Woolston Lippincott, M.D., Medical College of Virginia, '44, transferred his membership from the Charleston County Medical Society, S.C., when he came to Delaware in November. Specialty: Radiology. Office: Wilmington General Hospital. Dr. Lippincott has one daughter and likes gardening, electronics and travel.



Patrick F. Ashley, M.D., Dalhousie University, Nova Scotia, '50, is a Canadian by birth and has lived here for seven years. Photography and making home improvements are his hobbies, besides spending time with his three children. Delaware license: 1961. Specialty: Pathology. Office: Memorial Hospital.

McHenry Peters, Jr., M.D., University of Pennsylvania, '54, is a native Virginian, recently transferring his membership from the Lynchburg Academy of Medicine. A radiologist at Delaware Hospital, Dr. Peters has just moved into a new home on Clyth Drive with his wife and two small boys. He finds photography an absorbing hobby. License: Pennsylvania 1955; Virginia 1960.

President's Page

THE UNITED WAY OF LIFE

Giving for the benefit of others is an integral part of the American way of life. The ideal of free individuals unified by a spontaneous service to the common life is the never-to-be-forgotten bequest to the civilized world by the early Athenian democracy. Once a year, 1500 communities in the United States experience a graphic demonstration of "spontaneous service to the common life" through voluntary, federated giving to the financial support of voluntary agencies.

Voluntary agencies have been defined as "nongovernmental, self-governing organizations financed primarily by contributions from the public."[1] Agency governing boards consisting of interested and responsible citizens represent both the conscience of the community and the philosophy of public accountability in the raising and spending of philanthropic funds. As our society becomes more complex one is increasingly apt to lose sight of the needs of his neighbor. Impulse giving properly is being replaced by planned giving. The heart and mind can and should become a team in one's decision as to where, when and how to give.

The present day good Samaritan has an ally in the team work of United Community Funds and Councils, instruments which can measure agency effectiveness, report on unmet needs, give expression to community wish, and form a main artery over which help can flow steadily and strongly to meet human exigency. The United Way does this without separate fund raising efforts for each member agency.

A popular magazine[2] headed an editorial, "If It's a United Fund Agency, You Know It's One of the Good Ones." Herein is good reason to channel a large portion of our charitable contributions into our local United Fund. "There are three classes of residents in any community: those who live off of it, those who live in it, and those who live for it." The latter "recognize their political, social, and economic duties as citizens by taking an attitude of live civic brotherhood."[3]

Albert Schweitzer, M.D., has observed, "Reverence for life does not allow the scholar to live for his science alone, even if he is very useful to the community in so doing . . . It refuses to let the businessman imagine that he fulfills all legitimate demands in the course of his business activities. It demands from all that they sacrifice a portion of their own lives for others. Religion to me is only words until we roll up our sleeves and plunge into our work to make conditons what they ought to be."

Samuel C. McGee

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Auxiliary Affairs

PRESIDENT'S FINAL REPORT, 1960-61

The Woman's Auxiliary to the Medical Society of Delaware has a small membership and represents a small medical society in a small state. We consider this a great state of affairs because of the friendships that are made in a closely knit group. The Medical Society has supported the Auxiliary enthusiastically since its inception.

The American Medical Education Foundation has our interest and support and we raised $825.50 this year. This was done by use of Memorial and Appreciation cards as well as by county and state contributions.

The Bulletin of the Woman's Auxiliary to the American Medical Association has proved to be of great benefit to our active leaders and members. We urge all members to subscribe. Planning materials sent from National Auxiliary Headquarters are adequate, timely, and used by our chairmen.

Recently we had a joint legislative meeting with the Medical Society and our Auxiliary members have been busy with "operation coffee cup." The Executive Secretary of the Medical Society has compiled statistics on our state situation which are a great aid in this undertaking.

Our three counties meet in different ways. New Castle, our largest, has seven luncheon meetings per year; Kent has four luncheon meetings and Sussex, eight night meetings followed by social hours with the County Medical Society. As a consequence, programs and program needs vary.

As far as community and volunteer services are concerned, each member represents Auxiliary in her particular location or town. Almost all members are hard working volunteers in hospitals, Red Cross, PTA's, churches and many service organizations.

We have had a banner year for Recruitment for Paramedical Careers. Our chairman has planned a program for the Rotary Club of Wilmington and has been its guest speaker as well. She spoke to the Milford Lions Club and various other service organizations. At the request of Delaware's Department of Education, she has written an article to be included in the "Guidance Counselor Handbook" for use in the schools. At the present time she is serving as our Auxiliary representative on a state-wide coordinating committee for National Hospital Week.

Two of our members played leading roles in a training session for women in civil defense. The session was held at the State Control Center and our members gave a very informative demonstration of home nursing under emergency conditons.

In this highly organized state we find that we are working in many organizations, many with the same fine goals in view. Each member is aware, however, that she represents Medical Auxiliary every minute of every day and is trying to give the best that is in her.

I want to thank everyone in the Auxiliary for their fine cooperation this year. It has been a pleasure to work with all of them.

Mrs. J. Leland Fox

ANNUAL MEETING

Woman's Auxiliary to the Medical Society of Delaware
Friday, October 27, 1961 -:- Brandywine Country Club
Wilmington, Delaware

Put your low-back patient back on the payroll

Soma relieves stiffness –stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

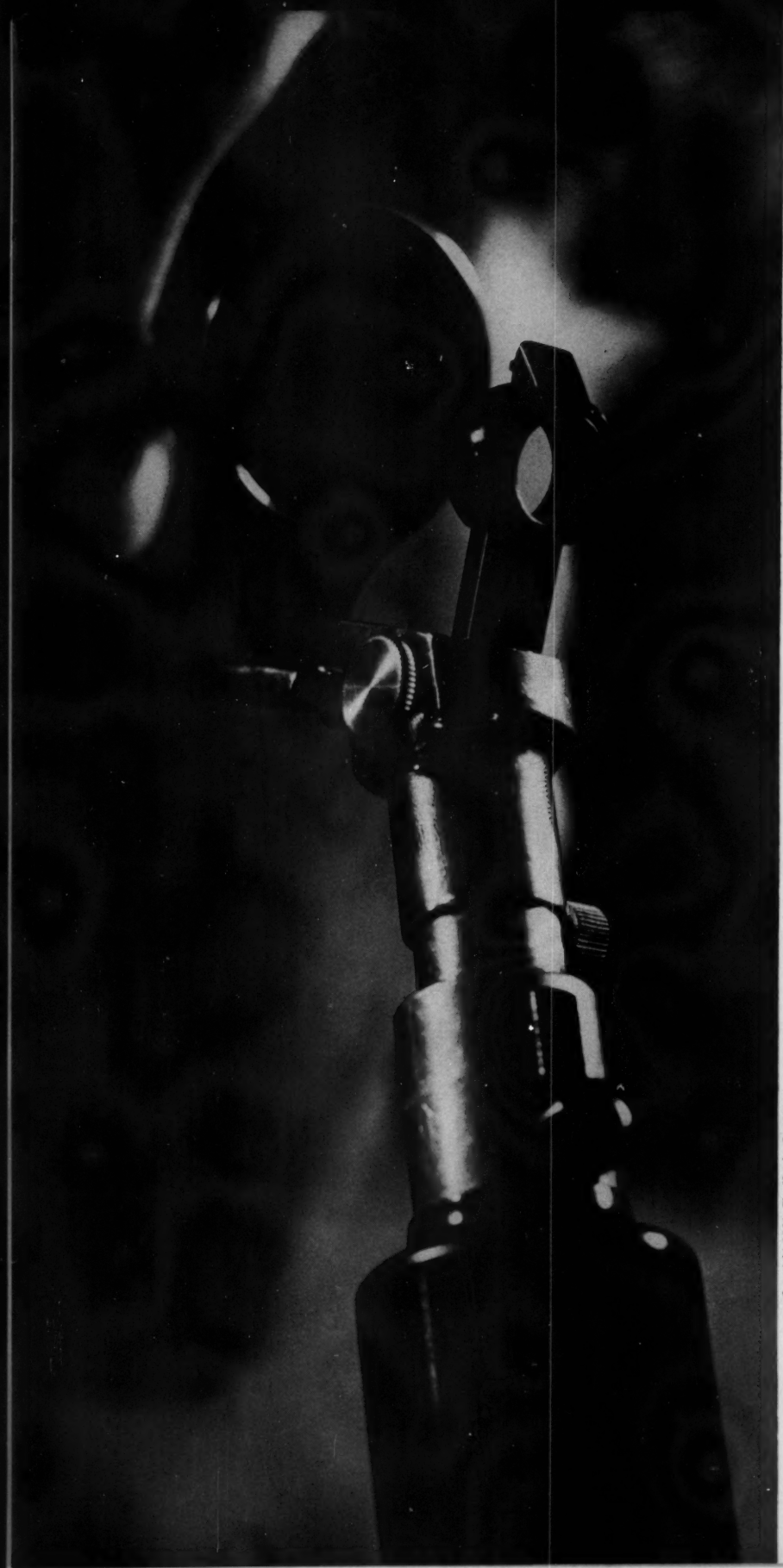
Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. USUAL DOSAGE: 1 TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey



in bacterial otitis media Panalba* promptly to gain precious therapeutic hours

In the presence of bacterial infection, taking a culture to determine bacterial identity and sensitivity is desirable—but not always practical.

A rational clinical alternative is to launch therapy at once with Panalba, the antibiotic that provides the best odds for success.

Panalba is effective (in vitro) against 30 common pathogens, including the ubiquitous staph. Use of Panalba *from the outset* (even pending laboratory results) can gain precious hours of effective antibiotic treatment.

SUPPLIED: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

USUAL ADULT DOSAGE: 1 or 2 capsules 3 or 4 times a day.

SIDE EFFECTS: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use are infrequent and consist principally of mild nausea and abdominal cramps.

Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.

Urticaria and maculopapular dermatitis, a few cases of leukopenia and agranulocytosis have been reported in patients treated with Albamycin. These side effects usually disappear upon discontinuance of the drug.

CAUTION: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken. Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.

*Trademark, Reg. U. S. Pat. Off. June, 1961

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Brāsivol is supplied in 3 abrasive grades, permitting gradual intensification of abrasive action as the acne improves. Also, Brāsivol Base (abrasive free) now available for acute inflammatory cases.

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REFERENCES:

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REFER TO PDR

Available only to physicians for their distribution—

Complete Cholesterol Depressant Menus and Recipe Book

A new, authoritative patient-aid . . . for professional distribution only

Now available for use in your practice from The Wesson People . . . easy-to-use manual of 40 pages, including all necessary diet instructions . . . menus, recipes, shopping and cooking guidance . . . all worked out for you . . . so arranged and printed that you have only to check the desired daily calorie level before giving the book to your patient.

You will find this book invaluable for treating patients with elevated serum cholesterol.

Complete menus for 10 days enable you to prescribe diets which are appetizing, nutritiously adequate and which can exert cholesterol depressant activity. Special attention has been given to constructing the menu patterns so that they adhere as closely as permissible to the patient's normal eating habits.

NRC Standards fulfilled. Each menu has been calculated to provide the proper daily allowance of proteins, vitamins and other nutrients as recommended by the Food and Nutrition Board of the National Research Council.

Weight control is achieved as each day's menu is given at 3 calorie levels—1200, 1800 and 2600 calories. You prescribe the level most desirable and modify as desired.

Variety and appetite appeal for patient are built into the menu plan to an extent not previously accomplished. Alternate choices for main dishes minimize monotony, encourage the patient to follow closely the menu plan you specify.

Complete recipes—65 in all—are included to assure that the specified menus provide prescribed levels of calories, the pre-determined ratio of poly-unsaturated to saturated fat, plus essential nutrients.

Dietary fat is controlled so that approximately 36% of the total calories are derived from fat and at least 40% of these fat calories are from poly-unsaturated components (linoleates) as found in pure vegetable oil. The replacement of saturated dietary fat by this percentage of poly-unsaturated fat has been found in clinical studies most effective in the reduction of serum cholesterol and in its maintenance at desirable levels. More liberal menus are provided for maintenance after the patient's progress indicates that desired therapeutic results have been accomplished.

Family meal preparation is simplified. The menus are planned around favorite foods having wide appetite appeal for all members of the household. Patients can entertain in comfort—enjoy cakes, cookies, snacks, prepared with recipes which meet medical requirements.

A high degree of satiety is achieved even at the lower calorie levels, because Wesson provides an unexcelled source of concentrated, slow-burning food energy.

Adaptable for use with diabetics. Carbohydrates have been calculated to fall within the acceptable range for patients to whom a diet planned for diabetes is important. Calories, which must be supplied from fat when the carbohydrate intake is limited, are provided by desirable poly-unsaturated vegetable oil.

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Wesson is 100% cottonseed oil—winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
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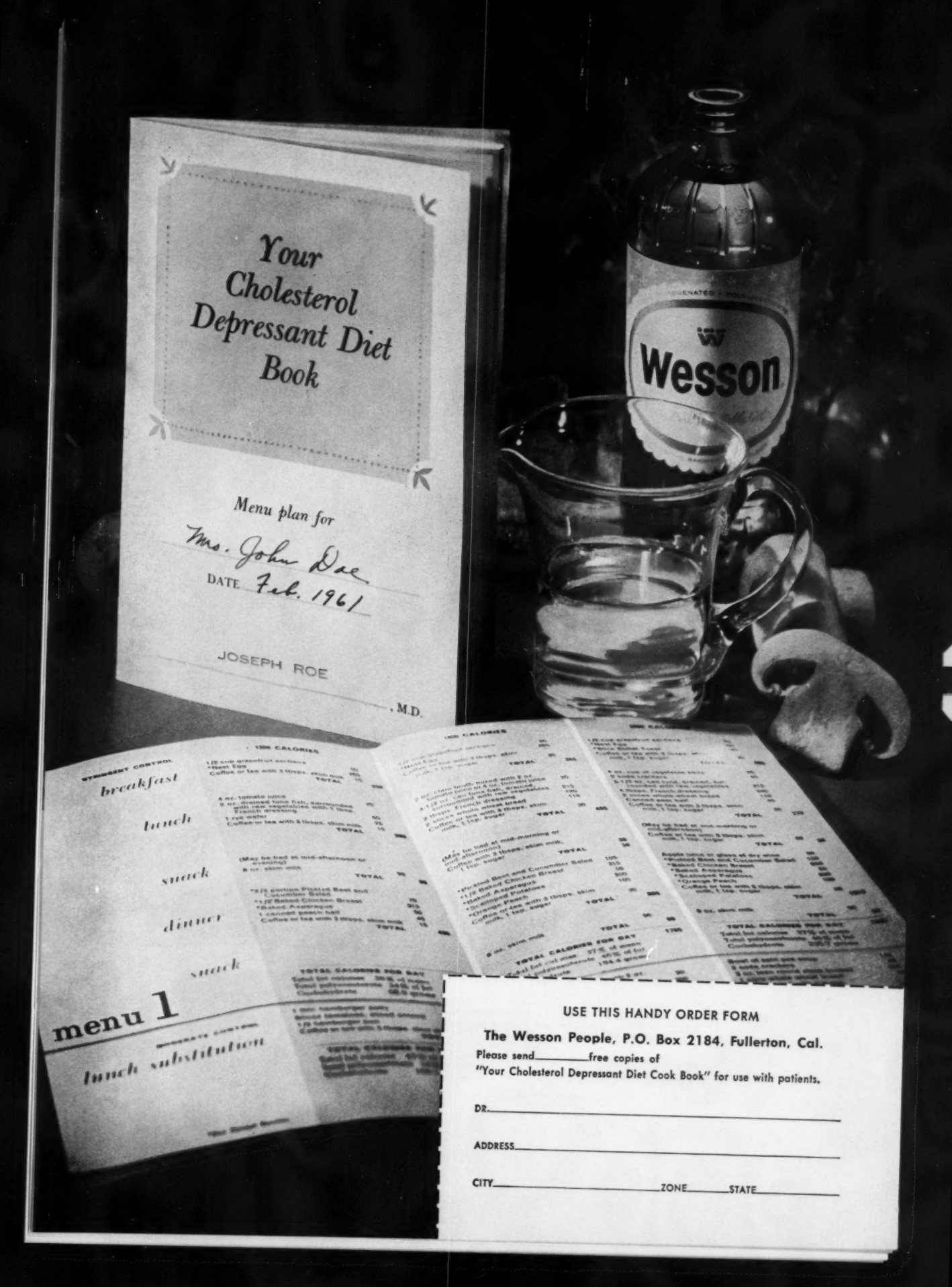
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.



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Please send_____free copies of
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DIMETAPP Extentabs contain Dimetane®(parabromdylamine [brompheniramine] maleate) 12 mg., phenylephrine HCl 15 mg., and phenylpropanolamine HCl 15 mg., a proved antihistamine and two outstanding decongestants. The dependable Extentab form provides sustained relief from the stuffiness, drip and congestion of sinusitis, colds and U. R. I. for 10-12 hours with a single dose.

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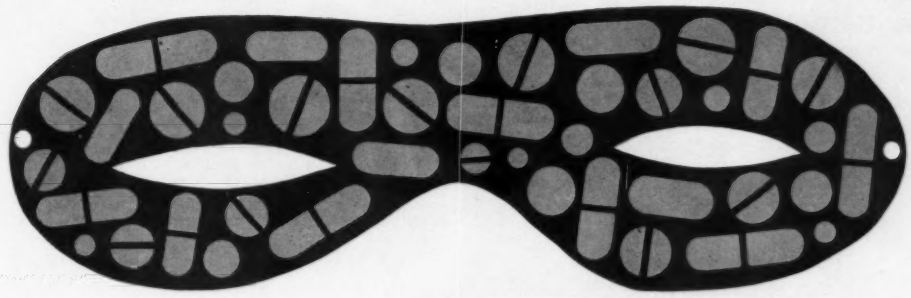


drugs anonymous

One of the several hastily conceived and potentially dangerous suggestions for reducing drug costs is generic-name prescribing. The proponents of generic-name prescribing claim that it will lower drug costs significantly and—through supervision by the Federal Government—provide quality equivalent to that of trademarked drugs. We maintain that these claims are false. Here are some authoritative answers to the principal questions posed by generic-name prescribing.

How much money would be saved if all prescriptions were written for generic-name drugs?

"The [Rhode Island] Division of Public Assistance examined 10,000 drug prescriptions for welfare recipients for the purpose of determining the actual savings . . . of generic versus trade-name drugs. The drugs had cost $28,000. Substituting generic drugs whenever possible would have provided a saving of less than 5 per cent. Syracuse has made a similar study of drug costs with comparable results."

Rhode Island Medical Journal,
January, 1961

Are the savings worth the risk of sacrificing quality?

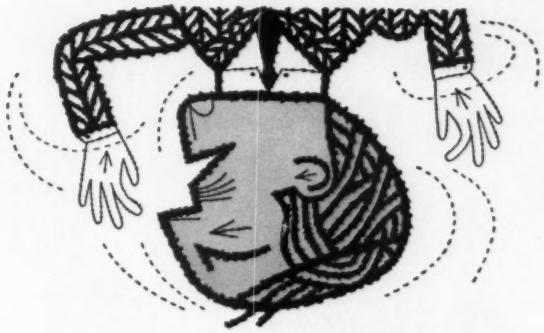
". . . it is unsafe [to prescribe generically] because there is not sufficient policing of our standards. . . ."

Lloyd C. Miller, Ph. D.
Director of Revision of the U.S.P.

"The naive belief that, if a product was not good, the FDA would prohibit its sale is just not realistic. . . . it is completely impossible for the FDA to check every batch of every product of every manufacturer. . . . Hence the integrity and reputation of the manufacturer assume unusual significance where drugs and health products are concerned."

Albert H. Holland, M.D.
formerly Medical Director of the
Food and Drug Administration

Smith Kline & French Laboratories, Philadelphia SK&F



vertigo is reversible

Antivert® stops vertigo

moderate to complete relief of symptoms in 9 out of 10 patients[1]

Prescribe one ANTIVERT tablet (or 1-2 teaspoonfuls ANTIVERT syrup) 3 times daily, before each meal, for prompt relief of vertigo, Meniere's syndrome and allied disorders. Side effects are short-lived, usually only harmless flushing and tingling associated with vasodilation. As with all vasodilators, ANTIVERT is contraindicated in severe hypotension and hemorrhage.

Supplied: Small blue-and-white scored tablets (meclizine HCl 12.5 mg. and nicotinic acid 50 mg.) in bottles of 100. Syrup (each 5 cc. teaspoonful contains meclizine HCl 6.25 mg. and nicotinic acid 25 mg.) in pint bottles. Prescription only. Bibliography available on request.

Reference: 1. Scal, J. C.: Eye Ear Nose & Throat Month. **38**:738 (Sept.) 1959.

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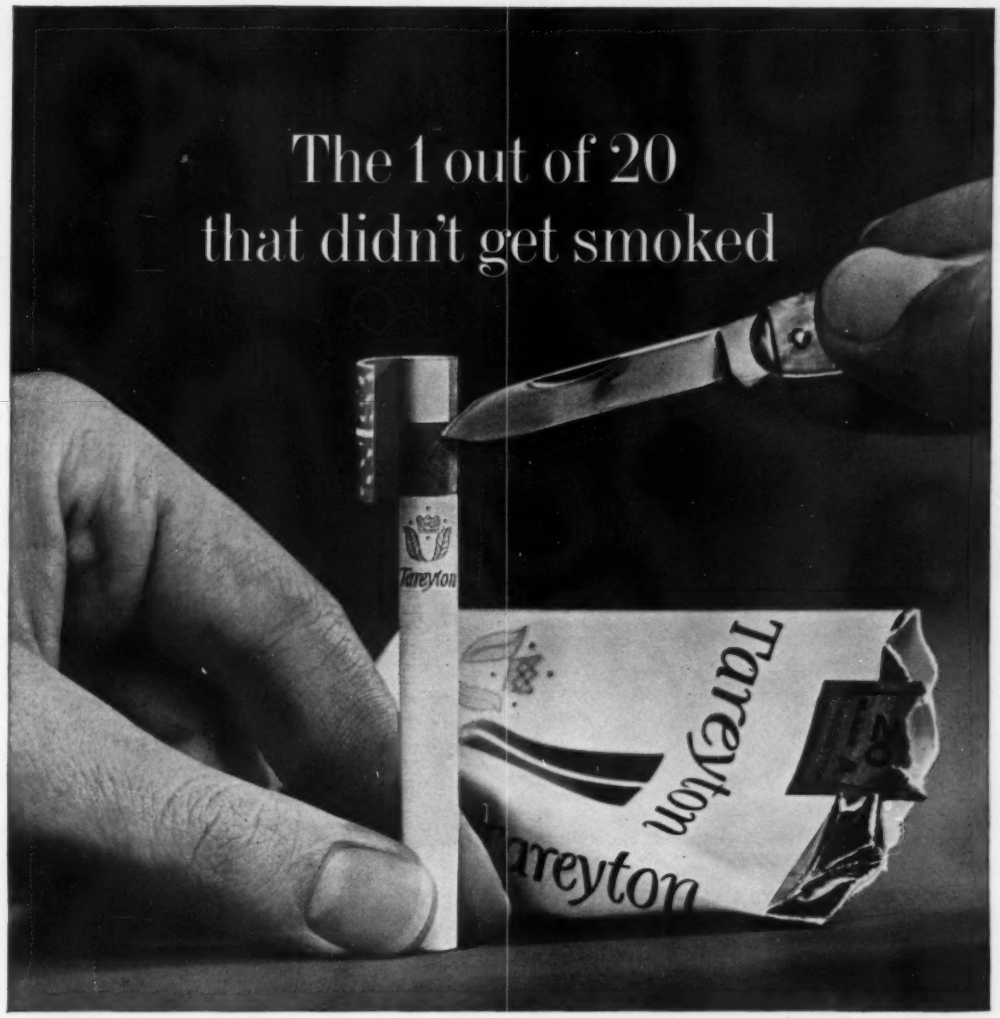
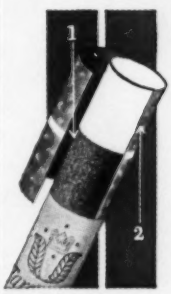


There's a lot of satisfaction in pointing out something good to a friend. That's why it sometimes happens that one cigarette out of a pack of Dual Filter Tareytons never does get smoked.

People open it to show its remarkable Dual Filter containing Activated Charcoal. They may not know why it works so well, but they do know this: it brings out the *best* taste of the *best* tobaccos. Yes, Tareyton delivers the flavor . . . and the Dual Filter does it!

Try a pack of Dual Filter Tareyton. We believe the extra pleasure they bring will soon have you passing the good word to your friends.



Tareyton delivers the flavor . . .
DUAL FILTER DOES IT!
HERE'S HOW: 1. It combines a unique inner filter of ACTIVATED CHARCOAL . . . definitely proved to make the taste of a cigarette mild and smooth . . .

2. with a pure white outer filter. Together they select and balance the flavor elements in the smoke. Tareyton's **flavor-balance** gives you the best taste of the best tobaccos.

DUAL FILTER Tareyton

Product of The American Tobacco Company — "Tobacco is our middle name" © A. T. Co.

is pharmaceutical advertising really "advertising"?

of course it is, though some have called it "education" . . . not <u>really</u> "advertising."

Of course it's "advertising"... a frankly competitive activity of the American private enterprise system to which this industry belongs. Of course it's "advertising"...created in the hope of getting the physician to note and read; of persuading him, by setting forth proven indications and advantages, to learn about a drug; and of thereby helping him alleviate suffering or cure disease by prescribing it.

"Advertising"? Surely! BUT indisputably different from any other advertising in the world (which is just what has led people to devise various different names for it). For in its proper role it communicates the vital information . . . good, bad, and indifferent . . . and it keeps the physician abreast of each useful new clinical application and each new danger revealed during increasing use of the drug.

There's been a lot of talk about "over-advertising", and there may have been occasional excesses. But consider the potential dangers, in this era of astonishing new drugs, of "under-advertising". . . in view of the complexity of modern drug therapy; the lag of 6 to more than 18 months before the appearance of definitive medical articles on new drugs; and the fact that there is no other source of such comprehensive information about a new agent as the company that ran it through the crucial gauntlet of animal pharmacology and clinical investigation.

This message is brought to you on behalf of the producers of prescription drugs. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D.C.

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THE COMPLETE Rx FOR COUGH CONTROL

cough sedative | antihistamine
nasal decongestant | expectorant

■ relieves cough and associated symptoms in 15-20 minutes ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains:

Hycodan®		
Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law permits oral prescription.

Literature on request

Endo

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*J.A.M.A. *169*:41-45 (Jan. 3) 1959.

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